NEW MEXICO DEPARTMENT OF HEALTH

# 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**

| | | | | |
|---|---|---|---|---|
| **Local Recipient:** | Turquoise Trail Fire District | | | 127089 |
| | *(EMS Service that will benefit)* | | | *(EMS Service #)* |
| **Mailing Address:** | 3 Turquoise Trail Court | Santa Fe | NM | 87508 |
| | *(Street/Mailing Address)* | *City)* | *(State)* | *( (Zip)* |
| | X 1 2 3 | 505-474-8282 | 505-690-4733 | 502-992-3073 |
| | *(EMS Region)* | *(Business Phone #)* | *(Emergency Phone #)* | *(Fax Phone #)* |
| **Contact Person:** | Kevin Barrows | District Chief | | cnclathesantafe@aol.com |
| | *(Name)* | *(Title)* | | *(E-mail Address)* |

| | | | | |
|---|---|---|---|---|
| **Applicant:** | Santa Fe County Fire Department | | | |
| | *(County or Municipality serving as Fiscal Agent)* | | | |
| **Mailing Address:** | 35 Camino Justicia | Santa Fe | NM | 87508 |
| | *(Mailing Address)* | *(City)* | *(State)* | *(Zip)* |
| **Contact Person:** | David Sperling | Fire Chief | | |
| | *(Name)* | *(Title)* | | |
| | 505-992-3076 | 505-992-3073 | dsperling@santafecountynm.gov | |
| | *(Telephone #)* | *(Fax Phone #)* | *(E-mail Address)* | |

# 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)** |
|---|---|---|---|
| ☐ **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). | ☐ **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.** | ☐ **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.** | ☒ **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.** |
| ☐ **Check if applicable** Service has Basic medical supplies and equipment. | ☐ **Check if applicable** Service has basic medical supplies and equipment. | ☐ **Check if applicable** Service has basic medical supplies and equipment. | ☒ **Check if applicable** Service has basic & advanced medical supplies and equipment. |
| ☐ **Check if applicable** Service has mutual aid agreements. **Attached copy(s)** | ☐ **Check if applicable** Service has mutual aid agreements. **Attached copy(s)** | ☐ **Check if applicable** Service has mutual aid agreements or other cooperative plan(s) with first response or transporting ambulance service(s). **Attach copy(s)** | ☒ **Check if applicable** Service has mutual aid agreements or other cooperative plan(s) with first response or transporting ambulance service(s). **Attach copy(s)** |
| ☐ **Check if applicable** Service has a designated Training Coordinator. | ☐ **Check if applicable** Service has a designated Training Coordinator. | ☐ **Check if applicable** Service has a designated Training Coordinator. | ☒ **Check if applicable** Service has a designated Training Coordinator. |
| ☐ **Check if applicable** The Service is, or plans to submit all runs to NMEMSTARS Database | ☐ **Check if applicable** The Service is submitting all runs to NMEMSTARS Database | ☐ **Check if applicable** The Service is submitting all runs to NMEMSTARS Database | ☒ **Check if applicable** The Service is submitting all runs to NMEMSTARS Database |
| ☐ **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. | ☐ **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. | ☐ **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. | ☒ **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. |
| ☐ **Check if applicable** Service has a Medical Director if performing skills requiring Medical Direction (see Scope of Practice) and appropriate medical protocols. | ☐ **Check if applicable** Service has a Medical Director if performing skills requiring Medical Direction (see Scope of Practice) and appropriate medical protocols. | ☐ **Check if applicable** Service has a Medical Director and appropriate BLS medical protocols. | ☒ **Check if applicable** Service has a Medical Director and appropriate BLS and ALS medical protocols. |
| ☐ **Check if applicable** Service complies with NM EMS Bureau Medical Rescue Certification regulations | ☐ **Check if applicable** Service complies with NM EMS Bureau Medical Rescue Certification regulations | ☐ **Check if applicable** Service complies with PRC 18.4.2 NMAC or EMS Bureau Medical Rescue Certification regulations | ☒ **Check if applicable** Service complies with PRC 18.4.2 NMAC or EMS Bureau Medical Rescue Certification regulations |
| | | | ☐ **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** *(Please list in appropriate category and provide adequate detail on each priority item)* | **Estimated Cost ($)** |
|---|---|---|
| **Repair and Maintenance:** | | |
| 1 | Medic 1, our primary response vehicle is almost 12 years old. | $2000 |
| | | |
| | | |
| **Training:** | | |
| 2 | Funds to include class fees, books, etc. for up to for new EMT-B's | $1600 |
| | | |
| | | |
| **Mileage & Per Diem:** | | |
| 6 | Various Expenses | $700 |
| | | |
| | | |
| **Supplies (Items Under $500):** | | |
| 4 | Expendables/Frequently Used Items | $800 |
| | | |
| | | |
| ****Capital Outlay (Items Over $500):** | | |
| 5 | New CO detectors, etc. | $1200 |
| | | |
| | | |
| **Other Operational Costs:** | | |
| 3 | New personal protective equipment, Jumpsuits, etc. | $1200 |
| | | |
| | | |
| **TOTAL AMOUNT OF REQUEST:** | | **$7500.00** |

* **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. Our top priority is acquiring the necessary funds to remain in operation on a day to day basis in a safe and effective manner. In order to do this, we need funds in order to keep up with the maintenance of Turquoise Trail Medic 1, which is our primary EMS response vehicle. It's area of operation often includes rugged terrain which results in significant wear and tear on the vehicle, on top of the fact that it has already seen nearly 12 year of use. Any funds granted to us would be used to make repairs of existing issues with the vehicle, as well as to repair any unforeseen issues. I believe this would be a worthwhile expenditure, because as a volunteer ILS service we can take lower priority patient transports in order to keep the ALS paid staff units available, thus creating a more efficient system.

2. Our second priority is to acquire funds to educate potential new EMTs, in order to more effectively serve the Turquoise Trail Fire district with emergency medical personnel. Funds would be used to pay for books, class fees and various other expenses associated with EMT basic and intermediate courses.

3. Our third priority is to acquire funds we can use to replace some our damaged or outdated personal protective equipment, including jumpsuits, safety glasses, and various other forms of protective equipment.

4. Our fourth priority is to acquire funds for daily operational costs, including the replacement of frequently used items, such as saline bags, IV start kits and catheters.

5.Our fifth priority would be the acquisition of new equipment, such as new CO detectors which we would use to ensure a safe work environment for our personnel.

6. Lastly, as we are not a service that has "daily" operation costs, any additional funds granted would be used for unforeseen expenses.

| SERVICE NAME: | Turquoise Trail Fire District |
|---|---|

## 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.

x Katherine Miller — County Manager

*Signature of Official Named Above* — *(Title)*

**The above was sworn and subscribed to before this** 16 **day of** January, 2015.

**Notary Public:** Ambra Garcia

**My commission expires:** 8/1/17

OFFICIAL SEAL
Ambra Garcia
NOTARY PUBLIC
STATE OF NEW MEXICO
MY COMMISSION EXPIRES: 8/1/17

(SEAL)

## PERSON COMPLETING FORM

| | | | | |
|---|---|---|---|---|
| **Name:** | Kevin Barrows | | | District Chief |
| | *(Name)* | | | *(Title)* |
| **Address:** | 3 Turquoise Trail Court | | | |
| | Santa Fe | New Mexico | 87508 | |
| | *(City)* | *(State)* | *(Zip)* | *(+4)* |
| | | 505-473-9125 | | |
| *(Work Phone)* | *(Home Phone #)* | *(Pager #)* | *(Cellular Phone #)* | *(E-mail Address)* |
| *Signature:* | | | | |

## FOR BUREAU USE ONLY

Reviewer: _____ Date Reviewed: _____

Approved: Yes No Final Award: _____

Comments/Problem:

Date Corrected:

Approved as to form
Santa Fe County Attorney
By:
Date: 1-12-15

# 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) | 2 | Siren | 2 |
| Flashlight | 2 | Spare Tire | 1 |
| Fuses (appropriate sizes) | 0 | Star of Life Displayed | 2 |
| Jack and Handle | 0 | Tool Box | 0 |
| Lug Wrench | 0 | Triage Tags for MCI's | 30 |
| Maps or Navigational equipment | 2 | U.S. DOT Emergency Response Guidebook | 2 |
| Patient Care Reports or Reporting System | 50 | Vehicle Registration | 1 |
| Roadway warning devices | 0 | Vehicle Spotlight or auxiliary lighting | 1 |
| Service Specific Protocols and guidelines | 1 | Warning Lights | 6 |
| Other: *(Specify)* | | | |
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## Communications Equipment

| Item Description | On Hand | Item Description | On Hand |
|---|---|---|---|
| Dispatch Radio UHF/VHF | 2 | Spare Batteries/charger system | 2 |
| EMSCOM (UHF) Radio | 2 | | |
| Other: *(Specify)* | | | |
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## Personal Protective Equipment

| Item Description | On Hand | Item Description | On Hand |
|---|---|---|---|
| Exam Gloves | 3 boxes | Helmet with Face Shield | 1 |
| Eye Protection | 6 safety glasses | N-95 mask (or > particulate mask) | 1 |
| Gloves (Leather or heavy duty) | 0 | Safety Vest/Jacket/(ANSI 2008 Compliant) | 2 |
| Hearing Protection | 0 | Splash Protection (disposable) | 2 |
| Other: *(Specify)* | | | |
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## Diagnostic Equipment

| Item Description | On Hand | Item Description | On Hand |
|---|---|---|---|
| Aneroid Sphygmomanometer with infant, pediatric, adult and obese size cuffs | 3 | | |
| End Title C02 monitoring device (optional) | 2 | Pulse Oximeter | 1 |
| Glucose Monitoring Instrument | 1 | Stethoscope | 1 |
| Penlights | 1 | Thermometer (Patient) | 1 |
| Other: *(Specify)* | | | |
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## Patient Compartment Equipment – If Applicable (Interior or Exterior)

| Basic Level | | | |
|---|---|---|---|
| **Item Description** | **On Hand** | **Item Description** | **On Hand** |
| Adhesive Tape 1" and 2" | 2 | Oxygen Delivery Devices(Adult, Child and Infant Sizes) | 4 |
| Auto Ventilator Devices (ATV/MTV) | 1 | Oxygen Supply Tubing | 4 |
| Bag Valve Mask Devices (Adult, Child and Infant) | 3 | Patient Restraints | 2 |
| Band-Aids (Assorted Sizes) | 1 | Pediatric Drug Dosage Tape or chart | 1 |
| Biohazard Clean-up Supplies | 15 | Pediatric Restraint device/car seat | 2 |
| Biohazard Waste bags | 15 | Pillows | 0 |
| Blankets | 6 | Portable Oxygen Equipment | 1 |
| Body Bags | 0 | Portable Suction Unit | 1 |
| Cervical Collars - Rigid (Adult, Child and Infant) | 6 | Seated Spinal Immobilization Device | 1 |
| Cervical Immobilization Devices | 1 | Semi-Automatic Defibrillator with Pads | 1 |
| Chair Stretcher | 1 | Semi-Automatic Defibrillator Batteries | 1 |
| Cold Pack | 3 | Sharps Container | 1 |
| Cold Weather Warming Devices | 3 | Sheets | 4 |
| Dressings Assorted (4x4, Kerlex, 2x2, etc.) | 20 | Shoulder/chest/extremity straps | 6 |
| Emesis Basin | 4 | Spinal Immobilization device/backboard | 2 |
| Field Stretcher (Scoop, Collapsible, Vacuum) | 0 | Splints, Extremity (Rigid, Air, Vacuum) | 4 |
| Foil Blanket | 0 | Sterile Burn Sheets | 3 |
| Hand Sanitizer | 3 | Sterile Gloves (Assorted Sizes) | 0 |
| Heat Pack | 3 | Sterile Water | 2 |
| Inhalation Therapy Equipment | 2 | Stokes Basket | 0 |
| Installed Oxygen System | 1 | Suction Catheters (Soft & Rigid) | 4 |
| Latex/Vinyl Gloves (Non-Sterile) (Small, Medium, Large, X-Large) | 1 each | Supraglottic Airway Devices | 6 |
| Long Backboard | 2 | Multi-lumen Airway Devices | 6 |
| Multi-level Stretcher | 1 | Laryngeal Airway Devices | 6 |
| Multi-Lumen Airways | 2 | Towels | 10 |
| Obstetrical Kit with Sterile Scissors or Equivalent to cutting umbilical cord | 2 | Traction Splint | 2 |
| Nasopharyngeal Airways | 6 | Trauma Dressings | 4 |
| Occlusive Dressings | 9 | Trauma Shears | 2 |
| On-Board Suction System | 1 | Triangular Bandages | 4 |
| On-Board Oxygen Supply | 1 | Urinal (Male and Female) | 2 |
| Oropharyngeal Airway (Sizes 0 – 5, Infant – Adult) | 6 | | |
| Pharmacological Equipment/Medications as approved by the NM Scope of Practice for EMT-Basic and the Service Medical Director | | | (Circle) Yes |

| | | | |
|---|---|---|---|
| | | | No |
| Other: *(Specify)* | | | |
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| **Advance Level** | | | |
| Alcohol and Betadine Prep Pads | 1 box | IV Fluid (Normal Saline, D5W, LR) | 6 |
| Cardiac Monitor/ Defibrillator/Ext. Pacer (Manual) | 1 | Laryngoscope Blades – Adult | 4 |
| Chest Decompression Catheters | 0 | Laryngoscope Blades –Peds | 4 |
| Cricothyroidotomy Kit | 0 | Laryngoscope Handle | 2 |
| EKG Monitor Electrodes | 2 bags | Magill Forceps | 1 |
| Electrode Defib Pads | 2 | Needles (Assorted Gauges) | 12 |
| End Tidal CO2 Detector | 0 | Pediatric Fluid Control Device | 1 |
| Endotracheal Tubes (Assorted) | 6 | Scalpels | 1 |
| Ext. Cardiac Pacing Pads | 2 | Syringes (1cc, 3cc, 5cc, 10cc) | 3 each |
| Infusion Pumps | 0 | Toomey Syringe (60cc) | 0 |
| Inhalation Therapy Equipment | 2 | Tubes, Blood Drawing (Assorted Sizes and Types) | 0 |
| Intraosseous Needles | 2 | Tubing, IV Administration (60gtts) | 4 |
| IV Catheters | 15 | Tubing, IV Administration Set (10gtts – 20gtts) | 4 |
| 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: *(Specify)* | | | |
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NEW MEXICO DEPARTMENT OF HEALTH

# 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:** | **Turquoise Trail Fire District – Santa Fe County Fire Department** *(EMS Service)* |

| | | | | | |
|---|---|---|---|---|---|
| **Mailing Address:** | 3 Turquoise Trail Court *(Mailing Address)* | | | | |
| | Santa Fe *(City)* | | NM *(State)* | 87508 *(Zip)* | *(+4)* |
| **Contact Person:** | Kevin Barrows *(Name)* | | District Chief *(Title)* | | |
| | 505-474-8282 *(Business Phone)* | 505-690-4733 *(Emergency Phone)* | 502-992-3073 *(Fax)* | cnclathesantafe@aol.com *(E-mail Address)* | |
| **Administration:** | Santa Fe County Fire Department *(County or Municipality)* | | | | |
| | 35 Camino Justicia *(Mailing Address)* | | | | |
| | Santa Fe *(City)* | | NM *(State)* | 87508 *(Zip)* | *(+4)* |
| **Contact Person:** | David Sperling *(Name)* | | Fire Chief *(Title)* | | |
| | 505-992-3076 *(Telephone #)* | 5050-992-3073 *(Fax Phone #)* | dsperling@santafecountynm.gov *(E-mail Address)* | | |
| **EMS Region:** | **Region I** X | **Region II** | **Region III** | | |

| **Physical Location of Ambulance/Medical Rescue Facilities** | | | | |
|---|---|---|---|---|
| **#1** | | | | |
| **Name of Facility:** | **Turquoise Trail Station 1** | | | |
| | | | | |
| | *Latitude* | | *Longitude* | |
| **Street Address:** | 3 Turquoise Trail Court | | | |
| | Santa Fe *(City)* | New Mexico *(State)* | 87508 *(Zip)* | *(+4)* |
| **#2** | | | | |
| **Name of Facility:** | Turquoise Trail Station 3 | | | |
| | | | | |
| | *Latitude* | | *Longitude* | |
| **Street Address:** | 10 River Street | | | |
| | Cerillos *(City)* | NM *(State)* | 87010 *(Zip)* | *(+4)* |

*(Use additional pages as necessary)*

| Service Name: | Turquoise Trail Fire District – Santa Fe County Fire Department *(EMS Service)* |
|---|---|

## SERVICE INFORMATION

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

| # of Years In Operation | 20 |
|---|---|

| EMS Calls | | | | | | Local Receiving Hospital(s) |
|---|---|---|---|---|---|---|
| Received By *(Mark One)* | | Dispatched By *(Mark One)* | | | | Christus St. Vincent Hospital |
| | Basic 911 | | Ambulance Service | X | Central Dispatch | Santa Fe Indian Hospital |
| X | Enhanced 911 | | Fire Department | | Location of Dispatch: | |
| | Local Phone | | 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 | | | Emergency Medical Dispatch Instructor | | |
| EMT Basic | | 2 | Nurse | | |
| EMT Intermediate | | 1 | Physician | | |
| EMT Paramedic | | | 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 |
|---|---|---|---|---|---|
| Kevin Barrows | EMT-I | 15078 | 3/2015 | 2014 | Volunteer |
| David Lopez | EMT-B | 12000487 | 3/31/16 | 2014 | Volunteer |
| John Alley | EMT-B | 14000462 | 3/9/15 | 2014 | Volunteer |
| | | | | | |
| | | | | | |
| | | | | | |

| Service Name: | Turquoise Trail Fire District – Santa Fe County Fire Department<br>*(EMS Service)* |
|---|---|

| Service Name: | Turquoise Trail Fire District – Santa Fe County Fire Department<br>*(EMS Service)* |
|---|---|

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 |
|---|---|---|---|---|
| Laird Graeser | 029994528 | 2014 | E | CPR |
| Albert Perea | 504969487 | 2014 | E | CPR |
| Miguel Romero | 507603904 | 2014 | E | CPR |
| Jamie Esquibel | 507789897 | 2014 | E | CPR |
| Remington Gillum | E2034974 | 2014 | E | CPR |
| | | | | |
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## GROUND AMBULANCE/MEDICAL RESCUE VEHICLES

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

| | | | |
|---|---|---|---|
| Type I: | Turquoise Trail Medic 1, Turquoise Trail Medic 3 | Type IV: | |
| Type II: | | Medical/Rescue: | Turquoise Trail Rescue 1 |
| 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. ***(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 |
|---|---|---|---|---|---|---|---|---|---|
| 2002 | Ford F450 | Ambulance | | TT M1 | | 4wd | 2 | 32483 | |
| 1996 | Ford F350 | Ambulance | | TTM2 | | 4wd | 2 | 66992 | |
| 2002 | Freightliner | Heavy Rescue | | TTR1 | | 4wd | 2 | 9266 | |
| | | | | | | | | | |
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| | | | | | | | | | |
| | | | | | | | | | |
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| | | | | | | | | | |

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

| Service Name: | Turquoise Trail Fire District – Santa Fe County Fire Department *(EMS Service)* |
|---|---|

| VEHICLE PREVENTIVE MAINTENANCE PROGRAM | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 1. Do you have a Vehicle Preventive Maintenance Program in place? | | Yes | X | No | | | | |
| **If "Yes", please attach a copy of your program.** | | | | | | | | |
| 2. Indicate the frequency of vehicle inspections: | | Daily | | Weekly | X | Monthly | | 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? | X | Yes | | No |
| 2. Are operational and medical protocols included in the Operations Plan? | X | Yes | | No |
| 3. What was the effective date of your Operations Plan? | **1996** | | | |
| 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? | | Yes | X | No | | | | | |
| **If "Yes", please attach description.** | | | | | | | | | |
| 2. Indicate the dates of this year's quality assurance review activities. | | | | | | | | | |
| Reviews are conducted: | | Daily | | Weekly | X | Monthly | | Quarterly | 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 | | | | | |
|---|---|---|---|---|---|
| **Name:** | David Sperling | | Chief | | |
| | *(Name)* | | *(Title)* | | |
| **Address:** | 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)* | |
| ***Signature:*** | | | | | |

| Service Name: | Turquoise Trail Fire District – Santa Fe County Fire Department (EMS Service) |
|---|---|

| SERVICE MEDICAL DIRECTOR | | | | | |
|---|---|---|---|---|---|
| **Name:** | David Rosen (Name) | | MD (Title) | | 2008-0628 (License #) |
| **Address:** | 35 Camino Justicia (Street/Mailing) | | Santa Fe (City) | NM (State) | 87508 (Zip) |
| (Work Phone) | (Home Phone #) | (Pager #) | 215-880-7131 (Cellular Phone #) | davidscottrosen@mac.com (E-mail Address) | |
| *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 (Name) | | Captain (Title) | 00014454 (License #) | Paramedic (Level) |
| **Address:** | 35 Camino Justicia (Street/Mailing) | | Santa Fe (City) | NM (State) | 87508 (Zip) |
| 505-992-3075 (Work Phone) | (Home Phone #) | (Pager #) | 505-670-6408 (Cellular Phone #) | mmestas@santafecountynm.gov (E-mail Address) | |
| ***Signature:** | | | | | |

| PERSON COMPLETING FORM | | | | | |
|---|---|---|---|---|---|
| **Name:** | Kevin Barrows (Name) | | District Chief (Title) | | |
| **Address:** | 3 Turquoise Trail Court (Street/Mailing) | | Santa Fe (City) | NM (State) | 87508 (Zip) |
| (Work Phone) | (Home Phone #) | (Pager #) | 505-473-9125 (Cellular Phone #) | (E-mail Address) | |
| ***Signature:** | | | | | |

**The above was sworn and subscribed to before this** 29th **Day of** December **, 20** 14

Donna R. Marina
**Notary Public**

Oct. 16, 2017
**My Commission Expires**

Seal

**** Notary is for the person completing form