



2013-0251-D-PW/MCS

**EMS FUND ACT
LOCAL FUNDING PROGRAM APPLICATION
FISCAL YEAR 2014**

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

Due Date: January 21, 2013

Local Recipient:	El Dorado Fire & 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) (Zip)</i>
	X 1	2	3	505-466-1204
	<i>(EMS Region)</i>	<i>(Business Phone #)</i>	<i>(Emergency Phone #)</i>	<i>(Fax Phone #)</i>
Contact Person:	Stephen Tapke		Chief	Eldoradofire@comcast.net
	<i>(Name)</i>		<i>(Title)</i>	<i>(E-mail Address)</i>

Applicant:	Santa Fe County			
	<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) (Zip)</i>
Contact Person:	David Sperling		Chief	
	<i>(Name)</i>		<i>(Title)</i>	
	505-690-3583	505-992-3073	dsperling@co.santa-fe.nm.us	
	<i>(Telephone #)</i>	<i>(Fax Phone #)</i>	<i>(E-mail Address)</i>	

Number of Years In Operation	Total EMS Runs 10/01/11 to 09/30/12 Entered into NMEMSTARS database.
35	397

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	Certification or Licensure Level	Certification or License Number	Certification or License Expiration Date	Paid/Volunteer
Dan Davidson	FR	11000584	03/31/2013	Volunteer
Gabriel Garcia	EMT-B	11000569	03/31/2014	Volunteer
Allison C. Brimacombe	EMT-B	12000483	03/31/2014	Volunteer
Karen Logan	EMT-B	00013853	03/31/2014	Volunteer
Christian Mee	EMT-I	09001373	03/31/2013	Volunteer
Ken Pinter	FR	11000572	03/31/2013	Volunteer

Audra Rees	EMT-B	11000654	03/31/2014	Volunteer
Glenn Saums	EMT-I	00010285	03/31/2014	Volunteer
Jay Selnick	EMT-B	07000828	03/31/2015	Volunteer
Wendy Servey	EMT-P	05000011	03/31/2013	Volunteer
Stephen Tapke	FR	07001014	03/31/2013	Volunteer
Elizabeth Jansen	RN	R44460	07/31/2013	Volunteer
Wayne Luttrell	EMT-B	02000698	03/31/2013	Volunteer

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)
Fifty percent (50%) of all runs covered by a trained first responder (within two years of the initial request for funding).	Eighty percent (80%) of all runs covered by a certified first responder or higher licensed medical personnel, minimum of two such personnel.	Eighty percent (80%) of all runs covered by a licensed EMT-Basic or higher licensed medical personnel, minimum of two such personnel.	X Eighty percent (80%) of all runs covered by a licensed intermediate or paramedic level personnel; or if EMD is utilized, 80% of all runs determined by dispatch to require an advance level response covered by licensed intermediate or paramedic level personnel and there must be at least one additional licensed EMT with the service.
Basic medical supplies and equipment.	Basic medical supplies and equipment.	Basic medical supplies and equipment.	X Basic & advanced medical supplies and equipment.
Attached copy of mutual aid agreement(s).	Attached copy of mutual aid agreement(s).	Attached copy of mutual aid agreement(s) or other cooperative plan(s) with first response or transporting ambulance service(s).	X Attached copy of mutual aid agreement(s) or other cooperative plan(s) with first response or transporting ambulance service(s).
A designated Training Coordinator.	A designated Training Coordinator.	A designated Training Coordinator.	X A designated Training Coordinator.
Submitting all runs to NMEMSTARS Database	Submitting all runs to NMEMSTARS Database	Submitting all runs to NMEMSTARS Database	X Submitting all runs to NMEMSTARS Database
	A Medical Director if performing skills requiring medical direction (see Scope of Practice) and appropriate medical protocols.	A Medical Director and appropriate medical protocols.	X A Medical Director and appropriate BLS and ALS medical protocols.
		Complies with PRC Reg. 18.4.2 NMAC if applicable or other such regulations as may be adopted by the PRC regarding registered medical rescue or the EMS Bureau regarding certificated ambulances.	X 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.
		Complies with Air Ambulance certification regulations 7.27.5 NMAC.	X Maintain at least one transport capable vehicle if

	if applicable.		appropriate within the local EMS System.
		N/A	Complies with Air Ambulance certification regulations, if applicable.
		X	Complies with PRC Reg. 18.4.2 NMAC if applicable or other such regulations as may be adopted by the PRC regarding registered medical - rescue or the EMS Bureau regarding certificated ambulances.

LIST OF ITEMS FOR WHICH FUNDS ARE REQUESTED

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.

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

*Priority (Rank Order)	Description of Items <i>(Please list in appropriate category and provide adequate detail on each priority item)</i>	Estimated Cost (\$)
2	Repair and Maintenance:	
	Oil change, 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 Materials, and Supplies	3500.00
	Mileage & Per Diem:	
	Supplies (Items Under \$500):	
	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		\$22,500.00
*Do not make all items Priority No. 1. Use each number only once. (Use additional sheets if necessary.)		

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 increase in call volume

2. Our Med units are aging and need increasing amounts of maintenance. Our equipment needs to be in working order and ready 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 is a priority and necessity to insuring top level service to our response area and surrounding response areas.

5. Our outdated equipment needs to be upgraded, especially the equipment on our older Med unit.

SERVICE NAME: El Dorado Fire and Rescue service

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 Katherine Miller OR County Manager or Chairman, Board of Commissioners
Santa Fe

Municipality Santa Fe **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:

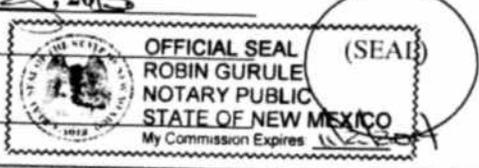
- That the funds received will be expended only for the purposes stated in the application and approved by the EMS Bureau.
- That authorization of the chief executive of the incorporated municipality or county is required, on behalf of the local recipient on vouchers issued by the treasurer of the political 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
Signature of Official Named Above

Approved as to form
Santa Fe County Attorney
By: *[Signature]* 1/10
(Title) Date: 1-8-13

The above was sworn and subscribed to before this 14 day of January, 2013

Notary Public: *[Signature]*



My commission expires: 11/2014

PERSON COMPLETING FORM

Name:	Christian Mee		Medical Captain	
	<i>(Name)</i>		<i>(Title)</i>	
Address:	144 Avenida Vista Grande			
	Santa Fe	NM	87508	
	<i>(City)</i>	<i>(State)</i>	<i>(Zip)</i>	<i>(+4)</i>
505-466-1204		505-690-4327	Mtruex_8@hotmail.com	
<i>(Work Phone)</i>	<i>(Home Phone #)</i>	<i>(Pager #)</i>	<i>(Cellular Phone #)</i>	<i>(E-mail Address)</i>
Signature:	<i>[Signature]</i> , Chief			

FOR BUREAU USE ONLY

Reviewer: _____ Date Reviewed: _____

Approved: Yes No Final Award: _____

Comments/Problem: _____

Date Corrected: _____



EMS ANNUAL SERVICE REPORT
Fiscal Year 2014
Due Date: January 21, 2013

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

Applicant:	Santa Fe County		
	<i>(County or Municipality serving as Fiscal Agent)</i>		
Mailing Address:	35 Camino Justicia		
	<i>(Mailing Address)</i>		
	Santa Fe	NM	87508
	<i>(City)</i>	<i>(State)</i>	<i>(Zip)</i>
Contact Person:	David Sperling	Chief, SFCFD	
	<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>

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		
	<i>(Street/Mailing Address)</i>		
	Santa Fe	NM	87508
	<i>(City)</i>	<i>(State)</i>	<i>(Zip)</i>
	X 1	2	3 505-466-1204
	<i>(EMS Region)</i>	<i>(Business Phone #)</i>	<i>(Emergency Phone #)</i>
Contact Person:	Stephen F. Tapke	Chief	Eldoradofire@comcast.net
	<i>(Name)</i>	<i>(Title)</i>	<i>(E-mail Address)</i>

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	Certification or Licensure Level	Certification or License Number	Certification or License Expiration Date	EVOC Course Date	Paid/Volunteer
Dan Davidson	FR	11000584	03/31/2013		Volunteer
Gabriel Garcia	EMT-B	11000569	03/31/2014		Volunteer
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Karen Logan	EMT-B	00013853	03/31/2014		Volunteer
Christian Mee	EMT-I	09001373	03/31/2013		Volunteer
Ken Pinter	FR	11000572	03/31/2013		Volunteer
Audra Rees	EMT-B	11000654	03/31/2014		Volunteer

Glenn Saums	EMT-I	00010285	03/31/2014		Volunteer
Jay Selnick	EMT-B	07000828	03/31/2015		Volunteer
Wendy Servey	EMT-P	05000011	03/31/2013		Volunteer
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Elizabeth Jansen	RN	R44460	07/31/2013		Volunteer
Wayne Luttrell	EMT-B	02000698	03/31/2013		Volunteer

GROUND AMBULANCE/MEDICAL RESCUE VEHICLES

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

Type I:	2	Type IV:	
Type II:		Medical/Rescue:	1 Heavy Rescue Truck
Type III:		Other - Explain:	

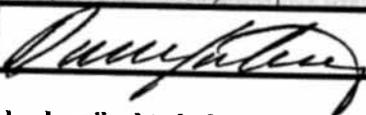
List all ambulance/medical rescue units, which are currently used by your service to provide patient transportation or first response. Indicate each vehicle's year, make, model, type (I, II, III, IV), license number, date of manufacture, whether two wheel or four wheel drive, patient capacity for supine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

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
99	Ford	F350	G-40519		12/1998	4wd	2	53,578	
92	Chevy	3500	G-09535		11/1991	4wd	2	43,861	
98	Freight-liner	FL50	G-38332		1/1998	2wd	0	10,955	

Please provide a list of all emergency response units in your department (include engines, brush trucks, etc.)
Engines 2,3,4,5 / Tower 1/ Brush 731,761/ Tenders 1,3

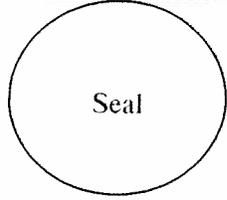
Type of Service (Must Check Only One)		Affiliation Type (Mark Primary Affiliation Only)	
<input checked="" type="checkbox"/>	Certified Ambulance- PRC ONLY	<input type="checkbox"/>	Private for-profit
<input type="checkbox"/>	Medical/Rescue Service (Non-transport)	<input type="checkbox"/>	Private non-profit
<input type="checkbox"/>	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"/>	If Certified PRC Ambulance Service you must submit PRC Certificate/Registration Number 42343	<input type="checkbox"/>	Municipality-based
		<input type="checkbox"/>	Tribal
		<input type="checkbox"/>	Other (Please Specify):

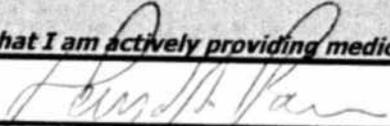
# of Years In Operation	Total EMS Runs 10/01/11 to 09/30/12 Entered into NMEMSTARS database.
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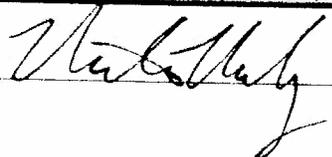
EMS CALLS				Local Receiving Hospital(s)		
Received By (Mark One)		Dispatched By (Mark One)		Christus St. Vincent's Regional Medical Center		
<input type="checkbox"/> Basic 911	<input type="checkbox"/> Ambulance Service	<input checked="" type="checkbox"/> Central Dispatch				
<input checked="" type="checkbox"/> Enhanced 911	<input type="checkbox"/> Fire Department	Location of Dispatch:				
<input type="checkbox"/> Local Phone	<input type="checkbox"/> Law Enforcement	<input checked="" type="checkbox"/> RECC				
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@co.santa-fe.nm.us	
<i>(Work Phone)</i>	<i>(Home Phone #)</i>	<i>(Pager #)</i>	<i>(Cellular Phone #)</i>		<i>(E-mail Address)</i>	
Signature:						

The above was sworn and subscribed to before this _____ day of _____, 20____

Notary Public My Commission Expires



SERVICE MEDICAL DIRECTOR				
Name:		David S. Rosen		Medical Director
		<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>
				215-880-7131
<i>(Work Phone)</i>		<i>(Home Phone #)</i>		<i>(Pager #)</i>
				davidscottrosen@mac.com
				<i>(Cellular Phone #)</i>
		<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:		Mike Neely		Asst.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>
505-992-3079				505-604-0478
<i>(Work Phone)</i>	<i>(Home Phone #)</i>	<i>(Pager #)</i>		<i>(Cellular Phone #)</i>
				mneely@santafecounty.org
		<i>(E-mail Address)</i>		
Signature:				

PERSON COMPLETING FORM				
Name:	Christian P. Mee		Medical Captain	
	(Name)		(Title)	
Address:	144 Avenida Vista Grande		Santa Fe	NM 87508
	(Street/Mailing)		(City)	(State) (Zip)
505-466-1204			505-690-4327	Mtruex_8@hotmail.com
(Work Phone)	(Home Phone #)	(Pager #)	(Cellular Phone #)	(E-mail Address)
Signature:	<i>CP Mee, Chief</i>			
SERVICE NAME:				

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		6	Nurse		1
EMT Intermediate		2	Physician		
EMT Paramedic		1	Driver		
Emergency Medical Dispatcher			Other		

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

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	Drivers License Number	EVOC Course Date	Class of NMDL	Other Medical Training
John Stokely	223-04-0956	2011	E	
Jason Judkins	467-87-5403	2011	E	
Ronald Chraft	503-84-8885	2011	E	
Stephen Cosban	114-56-9348	2011	D	
Vincent Faust	330-40-1964	2011	E	
Conrad Collier	601-74-9333	2011	E	

Terrance Reilly	060-48-8060	2011	D	

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)					

SERVICE NAME: El Dorado Fire and Rescue Service
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Physical Location of Ambulance/Medical Rescue Facilities				
#1				
Name of Facility:	El Dorado Fire & Rescue Service Station One			
	35 Degrees 32.5'N	105 degrees 54.4' W		
	<i>Latitude</i>	<i>Longitude</i>		
Street Address:	144 Avenida Vista Grande			
	Santa Fe	NM	87508	
	<i>(City)</i>	<i>(State)</i>	<i>(Zip)</i>	<i>(+4)</i>
#2				
Name of Facility:	El Dorado Fire & Rescue Service Station Two			
	35 degrees 32.36.3'N	105 degrees 57.86.8'N		
	<i>Latitude</i>	<i>Longitude</i>		
Street Address:				
	<i>(City)</i>	<i>(State)</i>	<i>(Zip)</i>	<i>(+4)</i>
Attach Additional Sheets If Necessary				

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?	3/17/1994 & 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
1/31/2012	5/31/2012	9/30/2102	+additional reviews	
2/29/2012	6/30/2012	10/31/2012	by Medical Director	
3/31/2012	7/31/2012	11/30/212	& Recc Dispaatch	
4/30/2012	8/31/2012			

SERVICE NAME: El Dorado Fire and Rescue Service

Equipment Inventory Report

Mandatory: If you have State Radio Equipment Please indicate it on a separate sheet and attach to Annual Service Report, if none indicate N/A.

On Board Vehicle Equipment: (Check if you're Unit has these Items)

Item Description	On Hand	Item Description	On Hand
Dispatch Radio UHF/VHF	Yes	Spare Tire	
EMSCOM (UHF) Radio	Yes	Lug Wrench	
EMSCOM Manual	Yes	Tool Box	
EMS Run Report	Yes	Fire Extinguisher	Yes
On-Board Suction System	Yes	Jack and Handle	Yes
Installed Oxygen System	Yes	Flares/Warning Devices	Yes
Triage Tags for MCI's	Yes	Fuses	Yes
Sharps Container	Yes	EMS Resource Manual	Yes
Vehicle Spotlight	Yes	Mutual Aid Guide	
Warning Lights	Yes	Star of Life Displayed	Yes

Siren	Yes	Service Name Displayed	Yes
Flashlight	Yes	Hazmat Guide	Yes
Roof Top Unit Number (Recommended)	Yes	EMS Medical Director's Handbook (Including Medical Protocols)	Yes
		Other: (Specify)	

Extrication Equipment: (Check if you're Unit has these Items)

Item Description	On Hand	Item Description	On Hand
Air Chisel Set	Yes	Manual Hydraulic Tool	Yes
Hay Hooks		Jack Hydraulic Tool	Yes
Tool "Come Along"	Yes	Clothing Protective (Bunker Gear)	Yes
Bar, Pry	Yes	Air Bag Set	Yes
Flashlight	Yes	Bolt Cutters	Yes
Blankets	Yes	Flood Lights/External	Yes
Fire Extinguisher	Yes	Heavy Hydraulic Tool	Yes
Generator	Yes	Cribbing Blocks	Yes
Rope	Yes	Hi-Lift jack	Yes
Halligan Tool	Yes	"Sawzall" Reciprocating Saw	Yes
Pneumatic Spreader	Yes	Fire Axe	Yes
Rescue Chain	Yes	Pike Pole	Yes
Hack Saw	Yes	Other: (Specify)	

SERVICE NAME: El Dorado Fire and Rescue Service

Patient Handling Equipment: (Check if you're Unit has these Items)

Item Description	On Hand	Item Description	On Hand
KED or Seated Spinal Immobilization Board	Yes	Field Stretcher (Scoop, Stokes, Collapsible, Vacuum)	Yes
Long Backboard	Yes	Sheets	Yes
Backboard Straps (Assorted)	Yes	Blankets	Yes
Chair Stretcher	Yes	Body Bags	
Yes Emesis Basin	Yes	Pillows	Yes
Urinal (Male and Female)	Yes	Biohazard Waste bags	Yes
Towels	Yes	Biohazard Clean-up Supplies	Yes
		Other: (Specify)	

Basic Life Support Drugs/Medical Equipment: (must indicate # stocked on truck if applicable)

Item Description	On Hand	Item Description	On Hand
Activated Charcoal		Adhesive Tape 1" and 2"	6 rolls each
Oral Glucose Preparations	4	Sterile Burn Sheets	3
Acetaminophen	1 box	Triangular Bandages	6
Aspirin	1 bottle 81 mg	Occlusive Dressings	2

Albuterol	8 (2.5 mg bullets)	Multi-Lumen Airways	10, 1 of each size of LMA, 1 of each size King
Ipratropium (Atrovent)	7 bullets	Pulse Oximeter	2
Epinephrine Auto- Injection Devices	0	Splints, Extremity (Rigid, Air, Vacuum)	1 full set of vacu splints, full set of cardboard splints, 3 sam splints
Epinephrine 1: 1,000	4 mini vials 1 MDV	Trauma Shears	2
Naloxone (Narcan)	.4mg x3 1.0 mg x 2	Blood Pressure Cuff (Adult, Child and Infant)	1 ea. Manual, 1ea. Automatic
Mark I Antidote Kit (or similar device)	0	Stethoscope	3
Cervical Immobilization Devices (Head blocks or Blanket Rolls)	6	Penlight	2
Cervical Collar Set (Rigid) (Adult, Child and Infant)	6	Sterile Water	4
Bag Valve Mask Devices (Adult, Child and Infant)	3	Obstetrical Kit with Sterile Scissors or Equivalent to cutting umbilical cord	2
Oropharyngeal Airway Set (Sizes 0 - 5, Infant - Adult)	3 each adult and pedi	Heat Pack	4
Trauma Dressings	4	Cold Pack	4
Dressings Assorted (4x4, Kerlex, 2x2, etc.)	6 kerlex, 10 2x2, 6 5x9, 50 4x4 sterile, 50 non sterile 4x4	Sterile Gloves (Assorted Sizes)	0
Cold Weather Warming Devices (Blankets, etc.)	6 blankets	Latex/Vinyl Gloves (Non-Sterile) (Small, Medium, Large, X-Large)	1 box each
Thermometer (Standard)	1	Portable Oxygen Equipment	1 with regulator plus 4 spare bottles
Thermometer (Cold Weather)		Oxygen Delivery Devices (Nasal Cannulas, Non-Rebreather Masks (Adult, Child and Infant Sizes)	6 adult NC, NRB, 2 pedi NC, NRB
Band-Aids (Assorted Sizes)	1 box	Glucometer	2

SERVICE NAME: El Dorado Fire District

Basic Life Support (Cont.)

Semi-Automatic Defibrillator AED Pads	1	Suction Catheters (Soft & Rigid)	4 rigid, 4 soft
Auto Ventilator Devices (ATV/MTV)		Portable Suction Unit	1
		Other: (Specify)	

Intermediate Life Support Drugs/Medical Equipment: (must indicate # stocked on truck if applicable)

Item Description	On Hand	Item Description	On Hand
All BLS Medications	Yes	All BLS Equipment	Yes
Epinephrine 1:10,000, Pre-filled	2	Alcohol and Betadine Prep Pads	10 each
Dextrose 50%	3	Syringes (1cc, 3cc, 5cc, 10cc)	5 ea.
Diphenhydramine HCL (Benadryl)	50 mg x3	Inhalation Therapy Equipment	4 sets
Glucagon	1	Tubing, IV Administration Set (10gtts - 20gtts)	8 sets
Narcotic Analgesics (Morphine, fentanyl, or dilaudid)	5 morphine, 2 fentanyl	Tubing, IV Administration (60gtts)	Above can be run at 60gtts/min
Nitroglycerin	1 bottle	Needles (Assorted Gauges)	5 ea. 18,20,22
Promethazine and anti-emetic agents	Zofran 4 mg x3	IV Fluid (Normal Saline, D5W, LR)	6 NS, 6 LR, 2D5W
Methyprednisolone	0	Tubes, Blood Drawing (Assorted Sizes and Types)	0
Hydroxycobalamine	0	Other: (Specify)	

Advanced Life Support Drugs/ Medical Equipment: (must indicate # stocked on truck if applicable)

Item Description	On Hand	Item Description	On Hand
All BLS & ILS Medications	Yes	Sodium Bicarbonate	2 bristojets
Adenosine	5 vials	Naloxone (Narcan)	
Amiodarone	2 vials	Nitroglycerine	
Atropine Sulfate	3 bristojet	Sodium Bicarbonate	
Benzodiazepines (Assorted)	3 versed, 2 valium	Thiamine	
Bretylium Tosylate	0	Topical anesthetic ophthalmic solutions	1 tube lidogel
Calcium Preparations	1 calcium chloride	Vasopressin	2 20 mg vial
Corticosteroids	1 solu-medrol	All BLS & ILS Equipment	Yes
Dopamine HCL	1 vial	Electrode Defib Pads	2 sets
Furosemide (Lasix)	40 mgx2	EKG Monitor Pads	30
Lidocaine	1 500 cc bag	Ext. Cardiac Pacing Pads	0
Magnesium Sulfate	1 gram x 3	Infusion Pumps	0
Narcotic Analgesics (other than ILS approved)		Scalpels	1

Oxytocin	1 vial	Chest Decompression Catheters	1 14-3" angiocath
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SERVICE NAME:	El Dorado Fire District
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Advanced Life Support (Cont.) (must indicate # stocked on truck if applicable)

Phenylephrine nasal spray	1 bottle	Intraosseous Needles	4
Manual Cardiac Monitor/ Defibrillator/Ext. Pacer	LP15	End Tidal CO2 Detector	2
Laryngoscope Handle	4	Toomey Syringe (60cc)	
Laryngoscope Blades – Adult	12	Cricothyroidotomy Kit	1
Laryngoscope Blades –Peds	12	Magill Forceps	2
Endotracheal Tubes (Assorted) (Adult – Peds)	2 sets	Other: (Specify)	

INFORMATION SYSTEM ANALYSIS

1. Are you currently collecting run data in an electronic format?				<input checked="" type="checkbox"/>	YES	<input type="checkbox"/>	NO
If yes, what software are you utilizing?							
2. Does your service currently own a computer?				<input checked="" type="checkbox"/>	YES	<input type="checkbox"/>	NO
Internet Access?	<input checked="" type="checkbox"/>	YES	<input type="checkbox"/>	NO			
Please list the person responsible for your data collection/information technology:							
Contact Name:	Karen Griego						
Phone Number:	505-992-3070						
E-mail:	kgriego@santafecounty.org						

FOR BUREAU USE ONLY

Date Entered (DB) _____	Reviewer: _____
Entered (CS): _____	Reviewer: _____
Approved: Yes No	
BUREAU COMMENTS:	
Correction: _____	Date Approved _____