



2013-0251-J-FD/LAS

**EMS FUND ACT  
LOCAL FUNDING PROGRAM APPLICATION  
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

<b>Local Recipient:</b>	Madrid Volunteer Fire District		127135	
	<i>(EMS Service that will benefit)</i>		<i>(EMS Service #)</i>	
<b>Mailing Address:</b>	5 Firehouse Lane	Madrid	NM	87010
	<i>(Street/Mailing Address)</i>		<i>(City)</i>	<i>(State) (Zip)</i>
	X 1	2	3	505-424-8006
	<i>(EMS Region)</i>	<i>(Business Phone #)</i>	<i>(Emergency Phone #)</i>	<i>(Fax Phone #)</i>
<b>Contact Person:</b>	Carl Hansen	Chief	solarwks@cybermesa.com	
	<i>(Name)</i>	<i>(Title)</i>	<i>(E-mail Address)</i>	

<b>Applicant:</b>	Santa Fe County			
	<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) (Zip)</i>
<b>Contact Person:</b>	Dave Sperling	Chief		
	<i>(Name)</i>	<i>(Title)</i>		
	505-992-3076	505-992-3073	dsperling@santafecounty.org	
	<i>(Telephone #)</i>	<i>(Fax Phone #)</i>	<i>(E-mail Address)</i>	

<b>Number of Years In Operation</b>	<b>Total EMS Runs 10/01/11 to 09/30/12 Entered into NMEMSTARS database.</b>
28	98

**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
Steve Shepherd	EMT-B	03001559	3/31/2014	Volunteer
Carl Hansen	EMT-B	10000871	3/31/2013	Volunteer
Clinton Anderson	EMT-B	07000693	3/31/2014	Volunteer
Stephanie Coulthard	EMT-I	07000690	3/31/2013	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, <b><u>minimum of two such personnel.</u></b>	X	Eighty percent (80%) of all runs covered by a licensed EMT-Basic or higher licensed medical personnel, <b><u>minimum of two such personnel.</u></b>		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 <b><u>licensed intermediate or paramedic level personnel and there must be at least one additional licensed EMT with the service.</u></b>
	Basic medical supplies and equipment.		Basic medical supplies and equipment.	X	Basic medical supplies and equipment.		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).		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.	X	A designated Training Coordinator.		A designated Training Coordinator.
	Submitting all runs to NMEMSTARS Database		Submitting all runs to NMEMSTARS Database	X	Submitting all runs to NMEMSTARS Database		Submitting all runs to NMEMSTARS Database
			A Medical Director if performing skills requiring medical direction (see Scope of Practice) and appropriate medical protocols.	X	A Medical Director and appropriate medical protocols.		A Medical Director and appropriate BLS and ALS medical protocols.
				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.		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, if applicable.		Maintain at least one transport capable vehicle if appropriate within the local EMS System.
							Complies with Air Ambulance certification regulations, if applicable.
							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 (\$)
	Repair and Maintenance:	
3	Service and maintenance, 2 Lifepack 1000 AED's	500.00
10	Service and maintenance, Homatro gasoline powered pump	500.00
	Training:	
2	Statewide and Region III EMT Conference registrations	1200.00
7	Other seminars that offer C.E.'s	300.00
8	EMT-B course at SFCC for new recruit	400.00
	Mileage & Per Diem:	
6	Per diem, 12 days (3 people by 4 days) at EMT Conferences @\$75/day	900.00
	Supplies (Items Under \$500):	
4	(2) adult and (2) infant CPR mannequins	750.00
5	(2) pulse oxymeters	300.00
9	Books for EMT-B course	200.00
1	Replenish medical consumables on an as needed basis	2000.00
	Other Operational Costs:	
	<b>TOTAL AMOUNT OF REQUEST</b>	<b>\$7050.00</b>

\*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.)

Priority 1: consumable supplies to be replaced on an as needed basis to ensure Rescue 1 is properly equipped.

Priority 2: due to our low call volume, attending the Statewide and Region 3 EMS Conferences are critical to maintaining our EMT-B skill levels

Priority 3: Our two CRPlus AED's will require service this year.

Priority 4: 2 additional adult and infant CPR mannequins to expand our community CPR program.

Priority 5: 2 additional pulse oxymeters for our jump kits.

Priority 6: per diem in support of the EMS Conference attendance.

Priority 7: registration at other seminars in the local area

Priority 8/9: to bring another member up to EMT-B licensure

Priority 10: our Homatro unit is due for service

SERVICE NAME: \_\_\_\_\_

**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** **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.

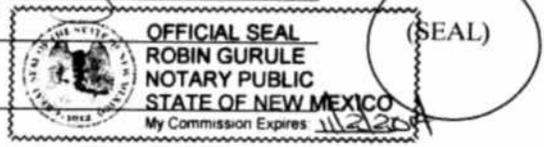
Approved as to form  
Santa Fe County Attorney  
By: Robert J. [Signature]  
Date: 1-8-13

Katherine Miller  
Signature of Official Named Above

(Title)

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

Notary Public: [Signature]



My commission expires: 11/2/2014

**PERSON COMPLETING FORM**

<b>Name:</b>	<u>Stephen Shepherd</u>	<u>EMS Captain</u>		
	(Name)	(Title)		
<b>Address:</b>	<u>PO Box 688</u>			
	<u>Madrid</u>	<u>NM</u>	<u>87010</u>	
	(City)	(State)	(Zip)	(+4)
		<u>505-780-0220</u>		
(Work Phone)	(Home Phone #)	(Pager #)	(Cellular Phone #)	(E-mail Address)
<b>Signature:</b>	<u>Steve Shepherd</u>			

**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

<b>Applicant:</b>	Santa Fe County			
	<i>(County or Municipality serving as Fiscal Agent)</i>			
<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>	Dave Sperling		Chief	
	<i>(Name)</i>		<i>(Title)</i>	
	505-992-3076	505-992-3073	dsperling@santafecounty.org	
	<i>(Telephone #)</i>	<i>(Fax Phone #)</i>	<i>(E-mail Address)</i>	

<b>Local Recipient:</b>	Madrid Volunteer Fire District			127135
	<i>(EMS Service that will benefit)</i>			<i>(EMS Service #)</i>
<b>Mailing Address:</b>	5 Firehouse Lane			
	<i>(Street/Mailing Address)</i>			
	Madrid	NM	87010	
	<i>(City)</i>	<i>(State)</i>	<i>(Zip)</i>	<i>(+4)</i>
	x 1 2 3	505-424-8006	505-670-2719	505-424-8006
	<i>(EMS Region)</i>	<i>(Business Phone #)</i>	<i>(Emergency Phone #)</i>	<i>(Fax Phone #)</i>
<b>Contact Person:</b>	Carl Hansen		Chief	
	<i>(Name)</i>		<i>(Title)</i>	
			solarwks@cybermesa.com	
			<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
Steve Shepherd	EMT-B	03001559	3/31/2014	11/2012	volunteer
Carl Hansen	EMT-B	10000871	3/31/2013	11/2012	volunteer
Clinton Anderson	EMT-B	07000693	3/31/2014	11/2012	volunteer
Stephanie Coulthard	EMT-I	07000690	3/31/2013	11/2012	volunteer

## GROUND AMBULANCE/MEDICAL RESCUE VEHICLES

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

Type I:	0	Type IV:	0
Type II:	0	Medical/Rescue:	1
Type III:	0	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
1994	Chevy 3500	Utility box	G14658		3/94	4WD	0	170352	N/A

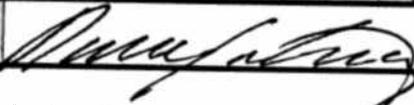
Please provide a list of all emergency response units in your department (include engines, brush trucks, etc.)

Engine 1, Tanker 1, Brush 1

Type of Service (Must Check Only One)	Affiliation Type (Mark Primary Affiliation Only)
<input type="checkbox"/> Certified Ambulance- PRC ONLY	<input type="checkbox"/> Private for-profit
<input checked="" 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 _____	<input type="checkbox"/> Municipality-based
	<input type="checkbox"/> Tribal
	<input type="checkbox"/> Other (Please Specify)

# of Years In Operation	Total EMS Runs 10/01/10 to 09/30/11 Entered into NMEMSTARS database.
28	98

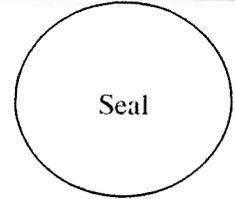
EMS CALLS			Local Receiving Hospital(s)
Received By (Mark One)	Dispatched By (Mark One)		
<input type="checkbox"/> Basic 911	<input type="checkbox"/> Ambulance Service	<input checked="" type="checkbox"/> Central Dispatch	St Vincent, Santa Fe
<input checked="" type="checkbox"/> Enhanced 911	<input type="checkbox"/> Fire Department	Location of Dispatch:	
<input type="checkbox"/> Local Phone	<input type="checkbox"/> Law Enforcement	<input checked="" type="checkbox"/> R.E.C.C.	

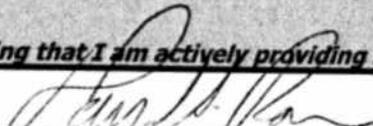
SERVICE DIRECTOR/CHIEF				
<b>Name:</b>	Dave Sperling		Chief	
	(Name)		(Title)	
<b>Address:</b>	35 Camino Justicia	Santa Fe	NM	87508
	(Street/Mailing)	(City)	(State)	(Zip)
505-992-3076			505-231-2776	dsperling@santafecounty.org
(Work Phone)	(Home Phone #)	(Pager #)	(Cellular Phone #)	(E-mail Address)
<b>Signature:</b>				

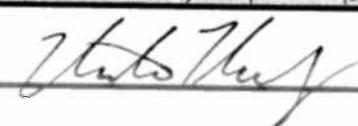
The above was sworn and subscribed to before this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

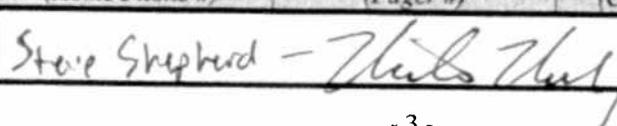
\_\_\_\_\_  
Notary Public

\_\_\_\_\_  
My Commission Expires



SERVICE MEDICAL DIRECTOR				
<b>Name:</b>	David Rosen		MD	2008-0628
	(Name)		(Title)	(License #)
<b>Address:</b>	35 Camino Justicia	Santa Fe	NM	87508
	(Street/Mailing)	(City)	(State)	(Zip)
			213-880-7131	davidscottrosen@mac.com
(Work Phone)	(Home Phone #)	(Pager #)	(Cellular Phone #)	(E-mail Address)
<b>*In signing this application I am certifying that I am actively providing medical direction for this EMS Service.</b>				
<b>*Signature:</b>				

SERVICE TRAINING COORDINATOR				
<b>Name:</b>	Mike Neely		Ops Chief	00012634 EMT-P
	(Name)		(Title)	(License #) (Level)
<b>Address:</b>	35 Camino Justicia	Santa Fe	NM	87508
	(Street/Mailing)	(City)	(State)	(Zip)
505-992-3079			505-604-0478	mneely@santafecounty.org
(Work Phone)	(Home Phone #)	(Pager #)	(Cellular Phone #)	(E-mail Address)
<b>Signature:</b>				

PERSON COMPLETING FORM				
<b>Name:</b>	Steve Shepherd		EMS Captain	
	(Name)		(Title)	
<b>Address:</b>	PO Box 688	Madrid	NM	87010
	(Street/Mailing)	(City)	(State)	(Zip)
			505-780-0220	Esteban69@prodigy.net
(Work Phone)	(Home Phone #)	(Pager #)	(Cellular Phone #)	(E-mail Address)
<b>Signature:</b>				



**SERVICE NAME:** Madrid Fire District

Physical Location of Ambulance/Medical Rescue Facilities				
<b>#1</b>				
<b>Name of Facility:</b>	Madrid Volunteer Fire District			
	35 deg 24' 17.67"	106deg 09' 14.67"		
	<i>Latitude</i>	<i>Longitude</i>		
<b>Street Address:</b>	5 Firehouse Lane			
	Madrid	NM	87010	
	<i>(City)</i>	<i>(State)</i>	<i>(Zip)</i>	<i>(+4)</i>
<b>#2</b>				
<b>Name of Facility:</b>				
	<i>Latitude</i>	<i>Longitude</i>		
<b>Street Address:</b>				
	<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?	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?	<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 checked="" type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Annually
DATES OF REVIEW					
DATE	DATE	DATE	DATE	DATE	
After each run	After each run	After each run	After each run	After each run	

**SERVICE NAME:** Madrid Fire District

**Equipment Inventory Report**

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

Item Description	On Hand	Item Description	On Hand
Dispatch Radio UHF/VHF	X	Spare Tire	X
EMSCOM (UHF) Radio	X	Lug Wrench	X
EMSCOM Manual	X	Tool Box	X
EMS Run Report	X	Fire Extinguisher	X
On-Board Suction System	X	Jack and Handle	X
Installed Oxygen System	X	Flares/Warning Devices	X
Triage Tags for MCI's	X	Fuses	X
Sharps Container	X	EMS Resource Manual	X
Vehicle Spotlight	X	Mutual Aid Guide	X
Warning Lights	X	Star of Life Displayed	X
Siren	X	Service Name Displayed	X
Flashlight	X	Hazmat Guide	X
Roof Top Unit Number (Recommended)		EMS Medical Director's Handbook (Including Medical Protocols)	X
		Other: <i>(Specify)</i>	

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

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

**SERVICE NAME:** Madrid Fire District

**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	X	Field Stretcher (Scoop, Stokes, Collapsible, Vacuum)	X
Long Backboard	X	Sheets	X
Backboard Straps (Assorted)	X	Blankets	X
Chair Stretcher	X	Body Bags	X
Emesis Basin	X	Pillows	
Urinal (Male and Female)		Biohazard Waste bags	X
Towels	X	Biohazard Clean-up Supplies	X
		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"	Lots
Oral Glucose Preparations	2 tubes	Sterile Burn Sheets	4
Acetaminophen	2 bottles	Triangular Bandages	6
Aspirin	2 bottles	Occlusive Dressings	2
Albuterol	6 vials	Multi-Lumen Airways	2
Ipratropium (Atrovent)		Pulse Oximeter	2
Epinephrine Auto- Injection Devices	6 doses	Splints, Extremity (Rigid, Air, Vacuum)	6
Epinephrine 1: 1,000		Trauma Shears	2
Naloxone (Narcan)	6 doses	Blood Pressure Cuff (Adult, Child and Infant)	2
Mark I Antidote Kit (or similar device)		Stethoscope	2
Cervical Immobilization Devices (Head blocks or Blanket Rolls)	3	Penlight	2
Cervical Collar Set (Rigid) (Adult, Child and Infant)	4	Sterile Water	4
Bag Valve Mask Devices (Adult, Child and Infant)	2	Obstetrical Kit with Sterile Scissors or Equivalent to cutting umbilical cord	2
Oropharyngeal Airway Set (Sizes 0 - 5, Infant - Adult)	2	Heat Pack	4
Trauma Dressings	4	Cold Pack	4
Dressings Assorted (4x4, Kerlex, 2x2, etc.)	Lots	Sterile Gloves (Assorted Sizes)	
Cold Weather Warming Devices (Blankets, etc.)	4	Latex/Vinyl Gloves (Non-Sterile) (Small, Medium, Large, X-Large)	2 boxes each
Thermometer (Standard)	1	Portable Oxygen Equipment	2
Thermometer (Cold Weather)		Oxygen Delivery Devices (Nasal Cannulas, Non-Rebreather Masks (Adult, Child and Infant Sizes)	Lots
Band-Aids (Assorted Sizes)	Lots	Glucometer	2

**SERVICE NAME:** Madrid Fire District

**Basic Life Support (Cont.)**

Semi-Automatic Defibrillator	4	Suction Catheters (Soft & Rigid)	2
AED Pads			
Auto Ventilator Devices (ATV/MTV)	1	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		All BLS Equipment	
Epinephrine 1:10,000, Pre-filled	2	Alcohol and Betadine Prep Pads	6
Dextrose 50%	3	Syringes (1cc, 3cc, 5cc, 10cc)	6
Diphenhydramine HCL (Benadryl)	2	Inhalation Therapy Equipment	2
Glucagon	2	Tubing, IV Administration Set (10gtts – 20gtts)	4
Narcotic Analgesics (Morphine, fentanyl, or dilaudid)		Tubing, IV Administration (60gtts)	
Nitroglycerin		Needles (Assorted Gauges)	6
Promethazine and anti-emetic agents		IV Fluid (Normal Saline, D5W, LR)	2
Methylprednisolone		Tubes, Blood Drawing (Assorted Sizes and Types)	
Hydroxycobalamine		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		Sodium Bicarbonate	
Adenosine		Naloxone (Narcan)	
Amiodarone		Nitroglycerine	
Atropine Sulfate		Sodium Bicarbonate	
Benzodiazepines (Assorted)		Thiamine	
Bretylium Tosylate		Topical anesthetic ophthalmic solutions	
Calcium Preparations		Vasopressin	
Corticosteroids		All BLS & ILS Equipment	
Dopamine HCL		Electrode Defib Pads	
Furosemide (Lasix)		EKG Monitor Pads	
Lidocaine		Ext. Cardiac Pacing Pads	
Magnesium Sulfate		Infusion Pumps	
Narcotic Analgesics (other than ILS approved)		Scalpels	
Oxytocin		Chest Decompression Catheters	

**SERVICE NAME:** Madrid Fire District

**Advanced Life Support (Cont.) (must indicate # stocked on truck if applicable)**

Phenylephrine nasal spray		Intraosseous Needles	
Manual Cardiac Monitor/ Defibrillator/Ext. Pacer		End Tidal CO2 Detector	
Laryngoscope Handle		Toomey Syringe (60cc)	
Laryngoscope Blades – Adult		Cricothyroidotomy Kit	
Laryngoscope Blades –Peds		Magill Forceps	
Endotracheal Tubes (Assorted) (Adult – Peds)		Other: <i>(Specify)</i>	

**INFORMATION SYSTEM ANALYSIS**

1. Are you currently collecting run data in an electronic format?  YES  NO  
 If yes, what software are you utilizing? Emergency Reporting
2. Does your service currently own a computer?  YES  NO
- Internet access?  YES  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 \_\_\_\_\_