

2013-0251-2-FD/KS



**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

Local Recipient:	Stanley Fire District		127031	
	<i>(EMS Service that will benefit)</i>		<i>(EMS Service #)</i>	
Mailing Address:	11 Kinsell Avenue West	Stanley	NM	87056
	<i>(Street/Mailing Address)</i>		<i>(City)</i>	<i>(State) (Zip)</i>
	X 1	2	3	505-281-4697
	<i>(EMS Region)</i>		<i>(Business Phone #)</i>	<i>(Emergency Phone #)</i>
Contact Person:	Linda T. Anaya	District Chief	lanaya@santafecounty.org	
	<i>(Name)</i>		<i>(Title) (E-mail Address)</i>	
			505-281-0325	
			<i>(Fax Phone #)</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) (Zip)</i>
Contact Person:	David Sperling	Chief		
	<i>(Name)</i>		<i>(Title)</i>	
	505-992-3070	505-992-3073	dsperling@santafecounty.org	
	<i>(Telephone #)</i>		<i>(Fax Phone #) (E-mail Address)</i>	

Number of Years In Operation	Total EMS Runs 10/01/11 to 09/30/12 Entered into NMEMSTARS database.
27	45

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
Keith Henry	EMT-I	05001640	3/31/13	Volunteer
Michelle Marshall	EMT-I	00010420	3/31/13	Volunteer
Nancy Adamson	EMT-B	02000936	3/31/13	Volunteer
Linda Anaya	EMT-B	09001373	3/31/14	Volunteer
June Huysman-Morris	EMT-B	02000939	3/31/14	Volunteer
James Morris	EMT-B	02000938	3/31/14	Volunteer
Alan Weingarten	EMT-B	10001365	3/31/13	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, <u>minimum of two such personnel.</u>	X	Eighty percent (80%) of all runs covered by a licensed EMT-Basic or higher licensed medical personnel, <u>minimum of two such personnel.</u>		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 <u>licensed intermediate or paramedic level personnel and there must be at least one additional licensed EMT with the service.</u>
	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).	X	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 (<u>defined as "available... 24 hours per day, 7 days per week"</u>) 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	Repair and maintenance of rescue unit and equipment	\$2000.00
	Training:	
1	Provide training and equipment for all EMS personnel	\$2000.00
	Airway manikin	\$1000.00
	Mileage & Per Diem:	
5	Travel and per-diem for out of district training	\$1000.00
	Supplies (Items Under \$500):	
2	Expendable supplies for rescue unit and jump kits	\$2000.00
	**Capital Outlay (Items Over \$500):	
4	Radios and pagers	\$2000.00
	Other Operational Costs:	
	TOTAL AMOUNT OF REQUEST	\$10,000.00

*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. It is necessary to inspect all equipment and rescue unit and perform maintenance as needed to ensure that all equipment is working properly at all times.
2. Continued training for current and future EMS personnel is a priority due to our rural setting and limited staffing.
3. Expendable supplies are always needed and must be replaced in a timely manner.
4. Radios and pagers are needed to replace/upgrade old communication equipment to narrow band.
5. Travel / per-diem is necessary to help cover the expenses for out of district training (ex. EMS Conference).

SERVICE NAME: Stanley 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 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:

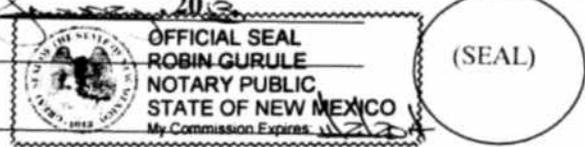
- That the funds received will be expended only for the purposes stated in the application and approved by the EMS Bureau.
- That authorization of the chief executive of the incorporated municipality or county is required, on behalf of the local recipient on vouchers issued by the treasurer of the political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

July 16/13
 By: [Signature]
 Santa Fe County Attorney
 Date: 1-8-13

Katherine Miller
 Signature of Official Named Above

The above was sworn and subscribed to before this 8 day of August, 2013

Notary Public: [Signature]



My commission expires: 11/22/14

PERSON COMPLETING FORM

Name:	Linda Anaya		District Chief	
	<i>(Name)</i>		<i>(Title)</i>	
Address:	11 Kinsell Avenue West			
	Stanley	NM	87056	
	<i>(City)</i>	<i>(State)</i>	<i>(Zip)</i>	<i>(+4)</i>
505-281-4697	505-832-9870	505-470-4941	lanaya@santafecounty.org	
<i>(Work Phone)</i>	<i>(Home Phone #)</i>	<i>(Pager #)</i>	<i>(Cellular Phone #)</i>	<i>(E-mail Address)</i>
Signature:				

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**

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Santa Fe, NM 87507
Attn: Ann Martinez
505-476-8233

Applicant:	Santa Fe County Fire Department			
	<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>	<i>(+4)</i>
Contact Person:	David Sperling		Chief	
	<i>(Name)</i>		<i>(Title)</i>	
	505-992-3070	505-992-3073	Dsperling@santafecounty.org	
	<i>(Telephone #)</i>	<i>(Fax Phone #)</i>	<i>(E-mail Address)</i>	

Local Recipient:	Stanley Fire District			127031
	<i>(EMS Service that will benefit)</i>			<i>(EMS Service #)</i>
Mailing Address:	11 Kinsell Avenue West			
	<i>(Street/Mailing Address)</i>			
	Stanley	NM	87056	
	<i>(City)</i>	<i>(State)</i>	<i>(Zip)</i>	<i>(+4)</i>
	X 1	2	3	505-281-4697
	<i>(EMS Region)</i>	<i>(Business Phone #)</i>	<i>(Emergency Phone #)</i>	<i>(Fax Phone #)</i>
Contact Person:	Linda T. Anaya		District Chief	lanaya@santafecounty.org
	<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
Keith Henry	EMT-I	05001640	3/31/14	4/2011	Volunteer
Michelle Marshall	EMT-I	00010420	3/31/13	4/2011	Volunteer
Nancy Adamson	EMT-B	02000936	3/31/13	4/2011	Volunteer
Linda Anaya	EMT-B	09001373	3/31/14	1/2012	Volunteer
June Huysman-Morris	EMT-B	02000939	3/31/14	4/2011	Volunteer
James Morris	EMT-B	02000938	3/31/14	4/2011	Volunteer
Alan Weingarten	EMT-B	10001365	3/31/13	4/2011	Volunteer

GROUND AMBULANCE/MEDICAL RESCUE VEHICLES

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

Type I:		Type IV:	
Type II:		Medical/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. (Use additional pages as necessary.) **MANDATORY**

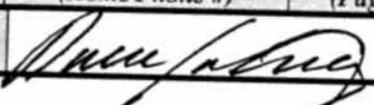
Year	Make And Model	Type of Vehicle	License Number	State Assigned EMS/COM Radio Unit Number	Manufacture Date	2WD or 4WD	Transport Patient Capacity	Mileage	Annual Inspection Date
1992	Ford	Horton	G-55376	R1	1992	4wd	2	94,398	

Please provide a list of all emergency response units in your department (include engines, brush trucks, etc.)
Engine 1, Engine 2, Engine 3, Tanker 1, Tanker 2, Brush 2, Brush 3, Command 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 type="checkbox"/> Medical/Rescue Service (Non-transport)	<input type="checkbox"/> Private non-profit
<input checked="" 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 10/01/11 to 09/30/12 Entered into NMEMSTARS database.
27	45

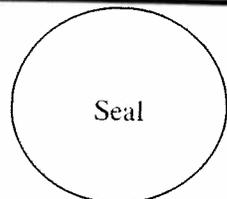
EMS CALLS			Local Receiving Hospital(s)
Received By (Mark One)	Dispatched By (Mark One)		
<input type="checkbox"/> Basic 911	<input type="checkbox"/> Ambulance Service	<input type="checkbox"/> Central Dispatch	
<input checked="" type="checkbox"/> Enhanced 911	<input type="checkbox"/> Fire Department	Location of Dispatch:	
<input type="checkbox"/> Local Phone	<input type="checkbox"/> Law Enforcement	<input checked="" type="checkbox"/> RECC Dispatch	

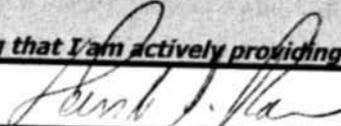
SERVICE DIRECTOR/CHIEF				
Name:	David Sperling		Chief	
	(Name)		(Title)	
Address:	35 Camino Justicia	Santa Fe	NM	87508
	(Street/Mailing)	(City)	(State)	(Zip)
505-992-3076		505-231-2776	dsperling@santafecounty.org	
(Work Phone)	(Home Phone #)	(Pager #)	(Cellular Phone #)	(E-mail Address)
Signature:				

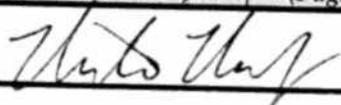
The above was sworn and subscribed to before this _____ day of _____, 20____

Notary Public

My Commission Expires



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

SERVICE TRAINING COORDINATOR				
Name:	Mike Neely		Ops Chief	EMT-P
	(Name)		(Title)	(License #)
Address:	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)
Signature:				

PERSON COMPLETING FORM				
Name:	Linda T. Anaya		District Chief	
	(Name)		(Title)	
Address:	11 Kinsell Avenue West	Stanley	NM	87056
	(Street/Mailing)	(City)	(State)	(Zip)
505-281-4697	505-832-9870	505-470-4941	lanaya@santafecounty.org	
(Work Phone)	(Home Phone #)	(Pager #)	(Cellular Phone #)	(E-mail Address)
Signature:				

SERVICE NAME: Stanley Fire District

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		5	Nurse		
EMT Intermediate		2	Physician		
EMT Paramedic			Driver		5
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	Social Security Number	EVOC Course Date	Drivers License Number	Other Medical Training
Robert Bell	525-97-1039	4/2011	500703334	
Sean Glackman	585-65-8482	4/2012	120616056	
Kurt Lermaseaux	585-70-6706	4/2011	004013336	
Taylor Livingston	585-95-6251	4/2011	506629144	
Tem Mitchell	452-21-7461	4/2011	031540810	

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 type="checkbox"/>	Weekly
	<input checked="" type="checkbox"/>	Monthly	<input type="checkbox"/>	Quarterly
3. Attach Annual Safety Inspection for all units (PRC ONLY)				

SERVICE NAME: Stanley Fire District

Physical Location of Ambulance/Medical Rescue Facilities				
#1				
Name of Facility:	Stanley Station 1			
	W 106 deg. 04 12.6		N 35 deg 8 35.0	
	<i>Latitude</i>		<i>Longitude</i>	
Street Address:	685 Highway 472			
	Stanley	NM	87056	
	<i>(City)</i>	<i>(State)</i>	<i>(Zip)</i>	<i>(+4)</i>
#2				
Name of Facility:	Stanley Station 2			
	W 105 deg 58 50		N 35 deg 8 55	
	<i>Latitude</i>		<i>Latitude</i>	
Street Address:	11 West Kinsell Avenue West			
	Stanley	NM	87056	
	<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 type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Quarterly
				<input type="checkbox"/> Annually
DATES OF REVIEW				
DATE	DATE	DATE	DATE	DATE

SERVICE NAME: Stanley Fire District

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

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

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

SERVICE NAME: Stanley 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	
Emesis Basin	X	Pillows	
Urinal (Male and Female)	X	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"	3 each
Oral Glucose Preparations		Sterile Burn Sheets	3
Acetaminophen	1 bottle	Triangular Bandages	5
Aspirin	1 bottle	Occlusive Dressings	2
Albuterol	6	Multi-Lumen Airways	
Ipratropium (Atrovent)		Pulse Oximeter	2
Epinephrine Auto- Injection Devices		Splints, Extremity (Rigid, Air, Vacuum)	12
Epinephrine 1: 1,000		Trauma Shears	4
Naloxone (Narcan)		Blood Pressure Cuff (Adult, Child and Infant)	3
Mark I Antidote Kit (or similar device)		Stethoscope	3
Cervical Immobilization Devices (Head blocks or Blanket Rolls)	5	Penlight	3
Cervical Collar Set (Rigid) (Adult, Child and Infant)	8	Sterile Water	1
Bag Valve Mask Devices (Adult, Child and Infant)		Obstetrical Kit with Sterile Scissors or Equivalent to cutting umbilical cord	2
Oropharyngeal Airway Set (Sizes 0 - 5, Infant - Adult)	2 each	Heat Pack	6
Trauma Dressings	5	Cold Pack	6
Dressings Assorted (4x4, Kerlex, 2x2, etc.)	5 each	Sterile Gloves (Assorted Sizes)	
Cold Weather Warming Devices (Blankets, etc.)	5	Latex/Vinyl Gloves (Non-Sterile) (Small, Medium, Large, X-Large)	1 box each
Thermometer (Standard)	1	Portable Oxygen Equipment	2
Thermometer (Cold Weather)		Oxygen Delivery Devices (Nasal Cannulas, Non-Rebreather Masks (Adult, Child and Infant Sizes)	5 each
Band-Aids (Assorted Sizes)	1 box each	Glucometer	2

SERVICE NAME: Stanley Fire District
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Basic Life Support (Cont.)

Semi-Automatic Defibrillator AED Pads	2	Suction Catheters (Soft & Rigid)	2
Auto Ventilator Devices (ATV/MTV)	1	Portable Suction Unit	1
		Other: <i>(Specify)</i>	

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		Alcohol and Betadine Prep Pads	1 box
Dextrose 50%		Syringes (1cc, 3cc, 5cc, 10cc)	
Diphenhydramine HCL (Benadryl)		Inhalation Therapy Equipment	
Glucagon		Tubing, IV Administration Set (10gtts – 20gtts)	
Narcotic Analgesics (Morphine, fentanyl, or dilaudid)		Tubing, IV Administration (60gtts)	
Nitroglycerin		Needles (Assorted Gauges)	
Promethazine and anti-emetic agents		IV Fluid (Normal Saline, D5W, LR)	
Methyprednisolone		Tubes, Blood Drawing (Assorted Sizes and Types)	
Hydroxycobalamine		Other: <i>(Specify)</i>	

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	
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	Yes
Dopamine HCL		Electrode Defib Pads	2
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: Stanley 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: (Specify)	

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:	

FOR BUREAU USE ONLY

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

BUREAU COMMENTS:

Correction: _____ Date Approved _____