

2013-0251 N-FD/MS



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

<b>Applicant:</b>	Santa Fe County Fire Department			
	<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>	David Sperling	Fire 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>
43	333

<b>LICENSED EMS PERSONNEL</b>				
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
Kevin Barrows	EMT-I	15078	3-2013	Volunteer
Garrett Grantham	EMT-I	9001427	3-2013	Volunteer
Chuck Ferran	EMT-B	11000494	3-2013	Volunteer
Erica Martinez	EMT-B	11000535	3-2013	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>		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>	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 <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.		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 ( <b><u>defined as "available ... 24 hours per day, 7 days per week"</u></b> ) 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.	X	Maintain at least one transport capable vehicle if 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**

<b>*Priority (Rank Order)</b>	<b>Description of Items</b> <i>(Please list in appropriate category and provide adequate detail on each priority item)</i>	<b>Estimated Cost (\$)</b>
	Repair and Maintenance:	
<b>3</b>	<b>Vehicle Maintenance and Repair</b>	<b>\$2000.00</b>
	Training:	
<b>2</b>	<b>EMS and Continuing Education CE's and New EMT-B</b>	<b>\$1000.00</b>
	Mileage & Per Diem:	
<b>6</b>	<b>Travel expenses for personnel to attend EMS Conference And Seminars</b>	<b>\$1000.00</b>
	Supplies (Items Under \$500):	
<b>4</b>	<b>Medical Supplies</b>	<b>\$1000.00</b>
	**Capital Outlay (Items Over \$500):	
<b>1</b>	<b>Ambulance Guerny ( past normal service life )</b>	<b>\$6000.00</b>
	Other Operational Costs:	
<b>5</b>	<b>Communication Equipment and Personal Protective Equip. To respond to medical emergencies-safety and accountability</b>	<b>\$2000.00</b>
<b>TOTAL AMOUNT OF REQUEST</b>		<b>#13,000.00</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.)

1. Gurney for Medic #1 has reached 10-year life and needs to be replaced
2. Training for new and current personnel. EMT re-Certification and CE's and attendance At EMS Conference
3. Currently both med units are over 10yrs old and require maintenance and repairs
4. Over 300 calls in 2012 requiring significant expense replacing medical supplies
5. Conversion of current radios to required mandated narrow banding, replacing outdated Communication equipment. Personnel uniforms and safety equipment for new and Current members
6. Travel expenses so personnel can attend EMS conference and Seminars to obtain And maintain EMS licensure, education and CE's

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

Katherine Miller

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.

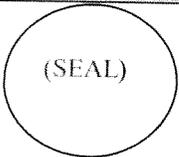
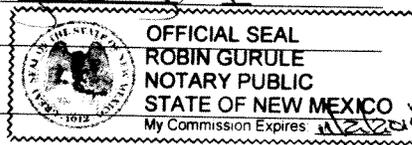
Approved as to form
Santa Fe County Attorney
By: [Signature]
Date: 1-8-13

Signature of Official Named Above

(Title)

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

Notary Public:



My commission expires: 12/2014

PERSON COMPLETING FORM

Name: Charlie Velarde (Name) Regional Chief (Title)
Address: 35 Camino Justicia
Santa Fe (City) New Mexico (State) 87508 (Zip) (+4)
505-992-3070 (Work Phone) 505-471-5719 (Home Phone #) 505-660-9619 (Cellular Phone #) charliesfnnm@q.com (E-mail Address)
Signature: Charlie Velarde

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

<b>Applicant:</b>	Santa Fe County Fire Department			
	<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>	David Sperling		Fire 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>	Turquoise Trail Fire District			127089
	<i>(EMS Service that will benefit)</i>			<i>(EMS Service #)</i>
<b>Mailing Address:</b>	3 Turquoise Trail Court			
	<i>(Street/Mailing Address)</i>			
	Santa Fe	NM	87508	
	<i>(City)</i>	<i>(State)</i>	<i>(Zip)</i>	<i>(+4)</i>
	X 1	2	3	
	<i>(EMS Region)</i>	<i>(Business Phone #)</i>	<i>(Emergency Phone #)</i>	<i>(Fax Phone #)</i>
<b>Contact Person:</b>	Kevin Barrows		District Chief	
	<i>(Name)</i>		<i>(Title)</i>	
			cnclathesantafe@aol.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
Kevin Barrows	EMT-I	15078	3-2013	10-1-12	Volunteer
Garrett Grantham	EMT-I	90014217	3-2013	10-1-12	Volunteer
Chuck Ferran	EMT-B	11000494	3-2013	10-1-12	Volunteer
Erica Martinez	EMT-B	11000535	3-2013	10-1-12	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:	2
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
02	F450	AMB	G62084		11-1-02	4	Y	25831	
96	F450	AMB	G31116		3-1-96	4	Y	66626	

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

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.
43	333

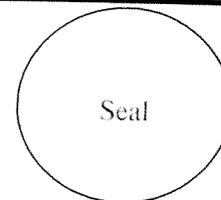
EMS CALLS				Local Receiving Hospital(s)
Received By (Mark One)	Dispatched By (Mark One)			
<input type="checkbox"/> Basic 911	<input type="checkbox"/> Ambulance Service	<input type="checkbox"/> Central Dispatch	Christus St. Vincents	
<input checked="" type="checkbox"/> Enhanced 911	<input type="checkbox"/> Fire Department	<input type="checkbox"/> Location of Dispatch:		
<input type="checkbox"/> Local Phone	<input type="checkbox"/> Law Enforcement	<input checked="" type="checkbox"/> RECC		
SERVICE DIRECTOR/CHIEF				
Name:	David Sperling		Fire Chief	
	(Name)		(Title)	

<b>Address:</b>	35 Camino Justicia	Santa Fe	Nm	87508
	(Street/Mailing)	(City)	(State)	(Zip)
505-992-3076				Dsperling@santafecounty.org
(Work Phone)	(Home Phone #)	(Pager #)	(Cellular Phone #)	(E-mail Address)
<b>Signature:</b>	<i>[Signature]</i>			

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	Medical Director		
	(Name)	(Title)		(License #)
<b>Address:</b>	35 Camino Justicia	Santa Fe	NM	87508
	(Street/Mailing)	(City)	(State)	(Zip)
		215-880-7131		
(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>				
<b>*Signature:</b>	<i>[Signature]</i>			

SERVICE TRAINING COORDINATOR				
<b>Name:</b>	Mike Neely	Asst Chief	12634	EMT-P
	(Name)	(Title)	(License #)	(Level)
<b>Address:</b>	35 Camino Justicia	Santa Fe	NM	87508
	(Street/Mailing)	(City)	(State)	(Zip)
505-992-3070		505-604-0478		mneely@santafecounty.org
(Work Phone)	(Home Phone #)	(Pager #)	(Cellular Phone #)	(E-mail Address)
<b>Signature:</b>	<i>[Signature]</i>			

PERSON COMPLETING FORM				
<b>Name:</b>	Charlie Velarde	Regional Chief		
	(Name)	(Title)		
<b>Address:</b>	35 Camino Justicia	Santa Fe	NM	87508
	(Street/Mailing)	(City)	(State)	(Zip)
505-992-3070		505-660-9619		charliesnm@q.com
(Work Phone)	(Home Phone #)	(Pager #)	(Cellular Phone #)	(E-mail Address)
<b>Signature:</b>	<i>[Signature]</i>			
<b>SERVICE NAME:</b>	Turquoise Trail 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		2	Nurse		
EMT Intermediate		2	Physician		
EMT Paramedic			Driver		6
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
Chris Corlett	31420652	10-1-12	E	CPR
Albert Perea	504969487	10-1-12	E	CPR
Laird Graeser	299945427	10-1-12	E	CPR
Eric Swanson	35475427	10-1-12	E	CPR
Miguel Romero	507603904	10-1-12	E	CPR
Mark Martinez	35523316	10-1-12	E	CPR

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:** Turquoise Trail Fire District

### Physical Location of Ambulance/Medical Rescue Facilities

<b>#1</b>				
<b>Name of Facility:</b>	TT Station # 1			
	<i>Latitude</i>		<i>Longitude</i>	
<b>Street Address:</b>	3 Turquoise Trail Court			
	Santa Fe	NM	87508	
	<i>(City)</i>	<i>(State)</i>	<i>(Zip)</i>	<i>(+4)</i>
<b>#2</b>				
<b>Name of Facility:</b>	TT Station # 3			
	<i>Latitude</i>		<i>Longitude</i>	
<b>Street Address:</b>	Cerrillos			
		NM	87508	
	<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
<b>DATES OF REVIEW</b>					
DATE	DATE	DATE	DATE	DATE	

<b>SERVICE NAME:</b>	Turquoise Trail Fire District
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## 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	2	Spare Tire	
EMSCOM (UHF) Radio	2	Lug Wrench	
EMSCOM Manual		Tool Box	
EMS Run Report	50	Fire Extinguisher	2
On-Board Suction System	2	Jack and Handle	
Installed Oxygen System	2	Flares/Warning Devices	
Triage Tags for MCI's	2	Fuses	
Sharps Container	8	EMS Resource Manual	
Vehicle Spotlight		Mutual Aid Guide	2
Warning Lights	2	Star of Life Displayed	2
Siren	2	Service Name Displayed	2
Flashlight	4	Hazmat Guide	2
Roof Top Unit Number (Recommended)	2	EMS Medical Director's Handbook (Including Medical Protocols)	2
		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		Manual Hydraulic Tool	
Hay Hooks		Jack Hydraulic Tool	
Tool "Come Along"		Clothing Protective (Bunker Gear)	
Bar, Pry		Air Bag Set	
Flashlight	2	Bolt Cutters	2
Blankets	10	Flood Lights/External	
Fire Extinguisher	2	Heavy Hydraulic Tool	
Generator		Cribbing Blocks	
Rope		Hi-Lift jack	
Halligan Tool		"Sawzall" Reciprocating Saw	
Pneumatic Spreader		Fire Axe	
Rescue Chain		Pike Pole	
Hack Saw		Other: <i>(Specify)</i>	

**SERVICE NAME:** Turquoise Trail 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	2	Field Stretcher (Scoop, Stokes, Collapsible, Vacuum)	2
Long Backboard	6	Sheets	8
Backboard Straps (Assorted)	6	Blankets	8
Chair Stretcher	2	Body Bags	2
Emesis Basin	8	Pillows	
Urinal (Male and Female)	8	Biohazard Waste bags	25
Towels	10	Biohazard Clean-up Supplies	2
		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"	4
Oral Glucose Preparations	4	Sterile Burn Sheets	5
Acetaminophen		Triangular Bandages	10
Aspirin	2 bottles	Occlusive Dressings	5
Albuterol	5	Multi-Lumen Airways	3
Ipratropium (Atrovent)	2	Pulse Oximeter	3
Epinephrine Auto- Injection Devices		Splints, Extremity (Rigid, Air, Vacuum)	4 sets
Epinephrine 1: 1,000	3	Trauma Shears	3
Naloxone (Narcan)	3	Blood Pressure Cuff (Adult, Child and Infant)	2sets
Mark I Antidote Kit (or similar device)		Stethoscope	2
Cervical Immobilization Devices (Head blocks or Blanket Rolls)	10	Penlight	5
Cervical Collar Set (Rigid) (Adult, Child and Infant)	10	Sterile Water	3
Bag Valve Mask Devices (Adult, Child and Infant)	4	Obstetrical Kit with Sterile Scissors or Equivalent to cutting umbilical cord	2
Oropharyngeal Airway Set (Sizes 0 - 5, Infant - Adult)	2 sets	Heat Pack	10x
Trauma Dressings	20x	Cold Pack	10x
Dressings Assorted (4x4, Kerlex, 2x2, etc.)	20x	Sterile Gloves (Assorted Sizes)	
Cold Weather Warming Devices (Blankets, etc.)	10	Latex/Vinyl Gloves (Non-Sterile) (Small, Medium, Large, X-Large)	2
Thermometer (Standard)	1	Portable Oxygen Equipment	2
Thermometer (Cold Weather)		Oxygen Delivery Devices (Nasal Cannulas, Non-Rebreather Masks (Adult, Child and Infant Sizes)	10x
Band-Aids (Assorted Sizes)	3 boxes	Glucometer	

**SERVICE NAME:** Turquoise Trail Fire District

### Basic Life Support (Cont.)

Semi-Automatic Defibrillator AED Pads	2	Suction Catheters (Soft & Rigid)	10
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	x	All BLS Equipment	x
Epinephrine 1:10,000, Pre-filled	3	Alcohol and Betadine Prep Pads	2 boxes
Dextrose 50%	2	Syringes (1cc, 3cc, 5cc, 10cc)	20
Diphenhydramine HCL (Benadryl)	2	Inhalation Therapy Equipment	10
Glucagon		Tubing, IV Administration Set (10gtts - 20gtts)	15
Narcotic Analgesics (Morphine, fentanyl, or dilaudid)		Tubing, IV Administration (60gtts)	25
Nitroglycerin	1	Needles (Assorted Gauges)	12
Promethazine and anti-emetic agents	2	IV Fluid (Normal Saline, D5W, LR)	20bags
Methyprednisoline		Tubes, Blood Drawing (Assorted Sizes and Types)	10
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	x	Sodium Bicarbonate	
Adenosine		Naloxone (Narcan)	2
Amiodarone		Nitroglycerine	1
Atropine Sulfate		Sodium Bicarbonate	
Benzodiazepines (Assorted)		Thiamine	
Bretylum Tosylate		Topical anesthetic ophthalmic solutions	
Calcium Preparations		Vasopressin	
Corticosteroids		All BLS & ILS Equipment	X
Dopamine HCL		Electrode Defib Pads	3x
Furosemide (Lasix)		EKG Monitor Pads	10x
Lidocaine		Ext. Cardiac Pacing Pads	
Magnesium Sulfate		Infusion Pumps	
Narcotic Analgesics (other than ILS approved)		Scalpels	
Oxytocin		Chest Decompression Catheters	

**SERVICE NAME:** Turquoise Trail Fire District

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

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

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?		Emergency Report			
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:	992-3070				
E-mail:	kgriego@santafecounty.org				

FOR BUREAU USE ONLY	
Date Entered (DB) _____	Reviewer: _____
Entered (CS): _____	Reviewer: _____
Approved:                      Yes                      No	
<b>BUREAU COMMENTS:</b>	
Correction: _____	Date Approved _____