



## Department of State Health Services Office of EMS & Trauma Systems Coordination

### Extraordinary Emergency Fund (EEF) Checklist

Name of Organization: _____	
If legal name is different, list legal name: _____	
Physical Address (not PO box): _____	
Mailing Address (if different): _____	
County of License and RAC/TSA: _____	
Tax ID#:	Population of Service Area:
What is your emergency request? _____	
What is the total dollar amount of your request? _____	
Organization Type: <input type="checkbox"/> EMS <input type="checkbox"/> FRO <input type="checkbox"/> Fire Department <input type="checkbox"/> Hospital <input type="checkbox"/> 911	
Service Type: <input type="checkbox"/> Rural <input type="checkbox"/> Urban <input type="checkbox"/> Volunteer Service <input type="checkbox"/> Paid Service <input type="checkbox"/> Emergency Transfer	
Number of miles to nearest EMS:	Level of their service:
Name of nearest EMS service: _____	

#### EMS Provider or First Responder Organization, complete this section

EMS license or FRO registration #:	
Service provides care to the following counties: _____	
Circle level of care: BLS ALS MICU or ( _____ with _____ capable)	
_____ % of 911 Calls _____ % of Transfer Calls	Average medical call distance, in miles:
Average medical call volume per month:	Square miles covered:
Number of ground ambulance(s):	Number of air ambulance(s):

#### Contact Information and Signature

Print name and title of contact person: _____	
Work phone ( _____ ) _____	Other phone ( _____ ) _____
Email Address: _____	
Print Alternate Contact and Title: _____	
Work Phone ( _____ ) _____	Other phone ( _____ ) _____
Alternate Email Address: _____	
By my signature, I attest information submitted for this emergency fund request is accurate and true.	
Signature: _____	Date: _____