



TEXAS DEPARTMENT OF STATE HEALTH SERVICES

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COMMISSIONER

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Regional Advisory Council REPORT OF EXPENDITURES FY ____ (911/1131/3588 RAC funds)

Counties: _____

Trauma Service Area: _____

Chair Person (Print): _____

Re: Utilization of Funds Received from the Emergency Medical Services (EMS) Trauma Care System Account (911 Funds) and Emergency Medical Services, Trauma Facilities, and Trauma Care Systems Fund (1131 Funds) and Designated Trauma Facilities and Emergency Medical Services Account (3588 Funds)

Total Amount of Allocation Received: \$ _____

Purchases/expenditures during period _____ - _____:
Contract Start Date Contract End Date

“Contractor shall submit a list of expenditures with **proof of payment. Examples of acceptable proof of payment include receipts showing paid in full, cancelled checks, invoices with \$0 balance, or a handwritten receipt must be noted as to how it was paid.”**

Supplies: Item: _____ Cost: \$ _____
Item: _____ Cost: \$ _____
Item: _____ Cost: \$ _____
Item: _____ Cost: \$ _____

Education & Training: Course: _____
Persons Trained: _____ Date: _____
Cost: \$ _____

Equipment: Type: _____ Cost: \$ _____
Type: _____ Cost: \$ _____
Type: _____ Cost: \$ _____

Communication Equipment: Type: _____ Cost: \$ _____

Type: _____ Cost: \$ _____

Other Operational Expenditures: _____

Anticipated Expenditures through August 31, _____, if any: _____

Total Cost: \$ _____

Anticipated Expenditures for any funds not expended by August 31. (Not required if entire contract amount is expended by August 31): _____

Total Cost: \$ _____

Name of person completing report (Print): _____

Title: _____ Phone: _____

RAC Authorized Signature: _____ Title _____

Name (Print): _____ Date _____

***Please attach additional page if necessary**