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:____EMS ___FRO Fire Department Hospital 911

Service Type: Rural Urban Volunteer Service Paid Service 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 #:	Current Staffing Numbers: ECA___ EMT___ EMT-1___ EMT-P___ LP___ Other___

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:

Fax completed form to (512) 834-6611 Revised Oct 2016

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