



**EMS ANNUAL SERVICE REPORT**  
**Fiscal Year 2011**  
**Due Date: January 15, 2010**

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

<b>Applicant:</b>				
	<i>(County or Municipality serving as Fiscal Agent)</i>			
<b>Mailing Address:</b>				
	<i>(Mailing Address)</i>			
	<i>(City)</i>	<i>(State)</i>	<i>(Zip)</i>	<i>(+4)</i>
<b>Contact Person:</b>				
	<i>(Name)</i>		<i>(Title)</i>	
	<i>(Telephone #)</i>	<i>(Fax Phone #)</i>	<i>(E-mail Address)</i>	

<b>Local Recipient:</b>				
	<i>(EMS Service that will benefit)</i>			<i>(EMS Service #)</i>
<b>Mailing Address:</b>				
	<i>(Street/Mailing Address)</i>			
	<i>(City)</i>	<i>(State)</i>	<i>(Zip)</i>	<i>(+4)</i>
	1	2	3	
	<i>(EMS Region)</i>	<i>(Business Phone #)</i>	<i>(Emergency Phone #)</i>	<i>(Fax Phone #)</i>
<b>Contact Person:</b>				
	<i>(Name)</i>		<i>(Title)</i>	
	<i>(E-mail Address)</i>			

<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	EVOC Course Date	Paid/Volunteer

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**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:	
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

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

Type of Service ( <i>Must Check Only One</i> )		Affiliation Type ( <i>Mark Primary Affiliation Only</i> )	
<input type="checkbox"/>	Certified Ambulance	<input type="checkbox"/>	Private for-profit
<input type="checkbox"/>	Medical/Rescue Service (Non-transport)	<input type="checkbox"/>	Private non-profit
<input type="checkbox"/>	Air Ambulance	<input 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"/>		<input type="checkbox"/>	Hospital-based
<input type="checkbox"/>	Other (Please Specify): _____	<input type="checkbox"/>	County-based
<input type="checkbox"/>		<input type="checkbox"/>	Municipality-based
<input type="checkbox"/>		<input type="checkbox"/>	Tribal
<input type="checkbox"/>		<input type="checkbox"/>	Other (Please Specify) : _____
<b>If Certified Ambulance Service:</b>			
<b>PRC Certificate/Registration Number:</b> _____			

List the Level of Service (FR, BLS, ILS, ALS, Critical/Specialty Care)	# of Years In Operation	Estimated Population of Service Area	Total # of EMS Runs 10/01/08 to 09/30/09 If different from NMEMSTARS database, please document and include reason.

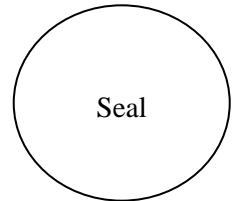
EMS CALLS				Local Receiving Hospital(s)	
Received By (Mark One)		Dispatched By (Mark One)			
<input type="checkbox"/>	Basic 911	<input type="checkbox"/>	Ambulance Service	<input type="checkbox"/>	Central Dispatch
<input type="checkbox"/>	Enhanced 911	<input type="checkbox"/>	Fire Department	<input type="checkbox"/>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

SERVICE DIRECTOR/CHIEF				
<b>Name:</b>				
	<i>(Name)</i>		<i>(Title)</i>	
<b>Address:</b>				
	<i>(Street/Mailing)</i>		<i>(City)</i>	<i>(State)</i> <i>(Zip)</i>
<i>(Work Phone)</i>	<i>(Home Phone #)</i>	<i>(Pager #)</i>	<i>(Cellular Phone #)</i>	<i>(E-mail Address)</i>
<b>Signature:</b>				

The above was sworn and subscribed to before this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_  
Notary Public

\_\_\_\_\_  
My Commission Expires



SERVICE MEDICAL DIRECTOR				
<b>Name:</b>				
	<i>(Name)</i>		<i>(Title)</i>	<i>(License #)</i>
<b>Address:</b>				
	<i>(Street/Mailing)</i>		<i>(City)</i>	<i>(State)</i> <i>(Zip)</i>
<i>(Work Phone)</i>	<i>(Home Phone #)</i>	<i>(Pager #)</i>	<i>(Cellular Phone #)</i>	<i>(E-mail Address)</i>
<b><i>*In signing this application I am certifying that I am actively providing medical direction for this EMS Service.</i></b>				
<b>*Signature:</b>				

SERVICE TRAINING COORDINATOR				
<b>Name:</b>				
	<i>(Name)</i>		<i>(Title)</i>	<i>(License #)</i> <i>(Level)</i>
<b>Address:</b>				
	<i>(Street/Mailing)</i>		<i>(City)</i>	<i>(State)</i> <i>(Zip)</i>
<i>(Work Phone)</i>	<i>(Home Phone #)</i>	<i>(Pager #)</i>	<i>(Cellular Phone #)</i>	<i>(E-mail Address)</i>
<b>Signature:</b>				

PERSON COMPLETING FORM				
<b>Name:</b>				
	<i>(Name)</i>		<i>(Title)</i>	
<b>Address:</b>				
	<i>(Street/Mailing)</i>		<i>(City)</i>	<i>(State)</i> <i>(Zip)</i>
<i>(Work Phone)</i>	<i>(Home Phone #)</i>	<i>(Pager #)</i>	<i>(Cellular Phone #)</i>	<i>(E-mail Address)</i>
<b>Signature:</b>				



**SERVICE NAME:**

<b>Physical Location of Ambulance/Medical Rescue Facilities</b>				
<b>#1</b>				
<b>Name of Facility:</b>	<input type="text"/>			
	<i>Latitude</i>	<i>Longitude</i>		
<b>Street Address:</b>	<input type="text"/>			
	<i>(City)</i>	<i>(State)</i>	<i>(Zip)</i>	<i>(+4)</i>
<b>#2</b>				
<b>Name of Facility:</b>	<input type="text"/>			
	<i>Latitude</i>	<i>Longitude</i>		
<b>Street Address:</b>	<input type="text"/>			
	<i>(City)</i>	<i>(State)</i>	<i>(Zip)</i>	<i>(+4)</i>
Attach Additional Sheets If Necessary				

<b>OPERATIONS PLAN</b>				
Please provide information on the Operations Plan for your service.				
1. Do you have an Operations Plan?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
2. Are operational and medical protocols included in the Operations Plan?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
3. What was the effective date of your Operations Plan?	<input type="text"/>			
4. Please provide a map of the coverage area for your service.				

<b>QUALITY ASSURANCE REVIEW</b>											
1. Do you have an internal quality assurance/improvement mechanism in place?							<input 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 type="checkbox"/>	Monthly	<input type="checkbox"/>	Quarterly	<input type="checkbox"/>	Annually
<b>DATES OF REVIEW</b>											
DATE	DATE	DATE	DATE	DATE							
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>							
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>							
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>							
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>							

**SERVICE NAME:**

## Equipment Inventory Report

### On Board Vehicle Equipment:

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

### Extrication Equipment:

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		Bolt Cutters	
Blankets		Flood Lights/External	
Fire Extinguisher		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:**

**Patient Handling Equipment:**

Item Description	On Hand	Item Description	On Hand
KED or Seated Spinal Immobilization Board		Field Stretcher (Scoop, Stokes, Collapsible, Vacuum)	
Long Backboard		Sheets	
Backboard Straps (Assorted)		Blankets	
Chair Stretcher		Body Bags	
Emesis Basin		Pillows	
Urinal (Male and Female)		Biohazard Waste bags	
Towels		Biohazard Clean-up Supplies	
		Other: <i>(Specify)</i>	

**Basic Life Support Drugs/Medical Equipment:**

Item Description	On Hand	Item Description	On Hand
Activated Charcoal		Adhesive Tape 1" and 2"	
Oral Glucose Preparations		Sterile Burn Sheets	
Acetaminophen		Triangular Bandages	
Aspirin		Occlusive Dressings	
Albuterol		Multi-Lumen Airways	
Ipratropium (Atrovent)		Pulse Oximeter	
Epinephrine Auto- Injection Devices		Splints, Extremity (Rigid, Air, Vacuum)	
Epinephrine 1: 1,000		Trauma Shears	
Naloxone (Narcan)		Blood Pressure Cuff (Adult, Child and Infant)	
Mark I Antidote Kit (or similar device)		Stethoscope	
Cervical Immobilization Devices (Headblocks or Blanket Rolls)		Penlight	
Cervical Collar Set (Rigid) (Adult, Child and Infant)		Sterile Water	
Bag Valve Mask Devices (Adult, Child and Infant)		Obstetrical Kit	
Oropharyngeal Airway Set (Sizes 0 – 5, Infant – Adult)		Heat Pack	
Trauma Dressings		Cold Pack	
Dressings Assorted (4x4, Kerlex, 2x2, etc.)		Sterile Gloves (Assorted Sizes)	
Cold Weather Warming Devices (Blankets, etc.)		Latex/Vinyl Gloves (Non-Sterile) (Small, Medium, Large, X-Large)	
Thermometer (Standard)		Portable Oxygen Equipment	
Thermometer (Cold Weather)		Oxygen Delivery Devices (Nasal Cannulas, Non-Rebreather Masks (Adult, Child and Infant Sizes)	
Band-Aids (Assorted Sizes)		Glucometer	

**SERVICE NAME:** **Basic Life Support (Cont.)**

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

**Intermediate Life Support Drugs/Medical Equipment:**

Item Description	On Hand	Item Description	On Hand
All BLS Medications		All BLS Equipment	
Epinephrine 1:10,000, Pre-filled		Alcohol and Betadine Prep Pads	
Dextrose 50%		Syringes (1cc, 3cc, 5cc, 10cc)	
Diphenhydramine HCL (Benadryl)		Inhalation Therapy Equipment	
Glucagon		Tubing, IV Administration Set (10 gtts – 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:**

Item Description	On Hand	Item Description	On Hand
All BLS & ILS Medications		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	
Dopamine HCL		Electrode Defib Pads	
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	

<b>SERVICE NAME:</b>	
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**Advanced Life Support (Cont.)**

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 –Ped.		Magill Forceps	
Endotracheal Tubes (Assorted) (Adult – Ped)		Other: ( <i>Specify</i> )	

<b>INFORMATION SYSTEM ANALYSIS</b>			
1. Are you currently collecting run data in an electronic format?			
	<input type="checkbox"/> YES		<input type="checkbox"/> NO
If yes, what software are you utilizing?			
2. Does your service currently own a computer?			
	<input type="checkbox"/> YES		<input type="checkbox"/> NO
Internet access?	<input type="checkbox"/> YES		<input type="checkbox"/> NO
<b>Please list the person responsible for your data collection/information technology:</b>			
Contact Name:			
Phone Number:			
E-mail:			

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