OHIO DEPARTMENT OF PUBLIC SAFETY
DIVISION OF EMERGENCEY MEDICAL SERVICES

TRAINING AND EQUIPMENT GRANT APPLICATION
PRIORITY 1

AGENCY ID #	EMS ORGANIZATION NAME	FEDERAL TAX I.D. #

MAILING ADDRESS	PO BOX	TELEPHONE #	FAX #
CITY	**STATE**	**ZIP CODE**	**COUNTY**

Your agency must be an Emergency Medical Services organization whose main responsibility is to provide continuous emergency medical services to the community pursuant to requests and/or calls from the public for emergency medical service response. Such EMS organizations must also meet one of the following. Please select which response best describes your agency.

☐ This agency provides emergency medical services and is established or operated by a township, municipality, village, city, county, joint fire district, joint ambulance district, or joint township fire district within the state.

☐ This agency provides emergency medical services, pursuant to a contract or letter, to a township, municipality, village city, county, joint fire district, joint ambulance district, or joint township fire district within the state.

☐ This agency does not provide emergency medical services under the operation of a township, municipality, village, city, county, joint fire district, joint ambulance district, or joint township fire district within the state OR pursuant to a contract or letter, to a township, municipality, village, city, county, joint fire district, joint ambulance district, or joint township fire district within the state.

☐ Yes ☐ No Does your agency provide patient treatment services?

☐ Yes ☐ No Is your agency in compliance with the submission of data to the Division of EMS as defined in Ohio Administrative Code (O.A.C.) 4765-4-08, and required under section 4765.06 of the Ohio Revised Code (R.C.)?

☐ Yes ☐ No Does your agency submit data under a different agency than your own?
If yes, provide the name of the agency used to submit data for your agency: _____

☐ Yes ☐ No Is your agency the primary provider of EMS services for a political subdivision?

Which funding sources does your agency receive?	☐ BILLING	☐ DONATIONS	☐ GRANTS	☐ TAX LEVY-PROPERTY	☐ TAX LEVY-INCOME	☐ TAX LEVY-SALES
	OTHER (describe)					

OPERATING BUDGET	SQAURE MILES COVERED	POPULATION COVERED	POPULATION INCREASE
NUMBER OF STATIONS	NUMBER OF EMS RUNS	☐ YES ☐ NO Does your agency provide emergency medical transport services?	

NUMBER OF EMS PATIENT TRANSPORTS WITHIN YOUR ANNUAL BUDGET PERIOD		PROVIDE THE NUMBER OF EACH TYPE OF EMS TRANSPORT VEHICLE YOUR AGENCY HAS: FRONTLINE RESERVE TOTAL
HIGHEST LEVEL OF SERVICE PROVIDED Volunteer %:	DESCRIBE YOUR STAFFING	AGENCY MEMBER CERTIFICATION LEVELS. ☐ EMR ☐ EMT ☐ AEMT ☐ PARAMEDIC
PLEASE PROVIDE A BRIEF DESCRIPTION OF YOUR PRIMARY RESPONSE AREA		

AUTHORIZING OFFICIAL		TELEPHONE #	E-MAIL ADDRESS
MEDICAL DIRECTOR		TELEPHONE #	PHYSICIAN LICENSE #
☐ Yes ☐ No Does your Medical Director meet the requirements as defined in section 4765-3-05 of the O.A.C.?			
CONTACT PERSON	TITLE	TELEPHONE #	E-MAIL ADDRESS