EMS ANNUAL SERVICE REPORT Fiscal Year 2019

Due Date: January 19, 2018

Submit to:
EMS Bureau 1301 Siler Rd Bldg. F
Santa Fe, NM 87507
Attn: Ann Martinez

Service Name:				
	(EMS Service)			
Mailing Address:				
	(Mailing Address)			
	(City)	*(State)*	*(Zip)*	*(+4)*
Contact Person:	*(Name)*		*(Title)*	
	(Business Phone)	*(Emergency Phone)*	*(Fax)*	*(E-mail Address)*
Administration:	*(County or Municipality)*			
	(Mailing Address)			
	(City)	*(State)*	*(Zip)*	*(+4)*
Contact Person:	*(Name)*		*(Title)*	
	(Telephone #)	*(Fax Phone #)*	*(E-mail Address)*	
EMS Region:	**Region I**	**Region II**	**Region III**	

Physical Location of Ambulance/Medical Rescue Facilities				
#1				
Name of Facility:				
	Latitude	*Longitude*		
Street Address:				
	(City)	*(State)*	*(Zip)*	*(+4)*
#2				
Name of Facility:				
	Latitude	*Longitude*		
Street Address:				
	(City)	*(State)*	*(Zip)*	*(+4)*
(Use additional pages as necessary)				

Service Name:	
	(EMS Service)

SERVICE INFORMATION

Type of Service *(Must Check Only One)*		Affiliation Type *(Mark Primary Affiliation Only)*	
☐	Certified **PRC** Ambulance	☐	Private for-profit
☐	Certified Medical/Rescue Service (Non-transport)	☐	Private non-profit
☐	Certified Medical/Rescue Service (Transport Capable)	☐	Fire Dept.-based
☐	Emergency Medical Dispatch Agency	☐	Law Enforcement or Department of Public Safety-based
☐	Special Event(s) Agency	☐	Clinic-based
☐	Air Ambulance	☐	Hospital-based
☐	Other (Please Specify):	☐	County-based
		☐	Municipality-based
PRC Certification #		☐	Tribal
Medical Rescue Certification #		☐	Other (Please Specify):

# of Years in Operation			

EMS Calls						Local Receiving Hospital(s)
Received By *(Mark One)*		**Dispatched by** *(Mark One)*				
☐	Basic 911	☐	Ambulance Service	☐	Central Dispatch	
☐	Enhanced 911	☐	Fire Department	☐	Location of Dispatch:	
☐	Local Phone	☐	Law Enforcement	☐		

EMERGENCY MEDICAL SERVICES PERSONNEL

LICENSED NUMBER OF PERSONNEL BY TRAINING LEVEL

	Paid (Indicate Part Time/Full Time	Volunteer*		Paid (Indicate Part Time/Full Time)	Volunteer*
EMS First Responder			Emergency Medical Dispatch Instructor		
EMT Basic			Nurse		
EMT Intermediate			Physician		
EMT Paramedic			Driver		
Emergency Medical Dispatcher			Other		

*Volunteer may include those paid by the run or other non-salary arrangement.

LICENSED EMS PERSONNEL

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	Licensure Level	License Number	License Expiration Date	EVOC Course Date	Paid/Volunteer

Service Name:

(EMS Service)

Service Name:	
	(EMS Service)

For Ground Ambulance/Medical Rescue Services Only				
GROUND AMBULANCE/MEDICAL RESCUE VEHICLE DRIVERS (Non-EMS Personnel)				
List all non-EMS personnel who are functioning as drivers for your service, and indicate the date of completion of their Bureau approved vehicle operator's course. Also, indicate any medical training they may have completed, for information purposes only. (Use additional sheets as necessary.)				
Name	**Driver's License Number**	**EVOC Course Date**	**Class of NMDL**	**Other Medical Training**

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. *(Mandatory)*

(Use additional pages as necessary)

Year	**Make And Model**	**Type of Vehicle**	**License Number**	**State Assigned EMSCOM 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.)

Service Name:	
	(EMS Service)

This section is a Mandatory Survey please fill out appropriately
(Failure to fill out will result in an incomplete application) *(2nd yr. of 3)*

EMERGENCY MEDICAL SERVICES PERSONNEL NEEDS ASSESSMENT

	Career and Paid Agencies			Volunteer Agencies*	
	Number of Actual Paid Staff	Additional Needed for Adequate or Optimal Staffing		Number of Volunteer staff	Additional Needed for Adequate Response and Staffing
Non - EMS Personnel (Drivers and/or CPR & First Aid only)					
Licensed EMS First Responder					
Licensed EMT Basic					
Licensed EMT Intermediate					
Licensed EMT Paramedic					
Total:					

This survey's goal is to determine the number of currently licensed caregivers who are active with an agency, and ***especially*** the number of additional licensed First Responders, EMT Basics, EMT – Intermediates, and Paramedics **needed** throughout the state. This information will help with the formulation of a plan to address this need.

***Note:**

- **Volunteer organizations:** please list all volunteer staff, even if those volunteers receive a per – run or other non-salary reimbursement.
- If your volunteer organization doesn't require a specific licensure level but needs additional licensed personnel, please select the lowest level of licensure that will meet your staffing needs. i.e don't list Paramedic when an EMT –Basic would suffice. Or, don't list First Responder if you really need EMTs.

VEHICLE PREVENTIVE MAINTENANCE PROGRAM

1. Do you have a Vehicle Preventive Maintenance Program in place?					☐	Yes	☐	No
If "Yes", please attach a copy of your program.								
2. Indicate the frequency of vehicle inspections:	☐	Daily	☐	Weekly	☐	Monthly	☐	Quarterly
3. Attach Annual Safety Inspection for all units. **(PRC ONLY)**								

OPERATIONS PLAN

Please provide information on the Operations Plan for your service.

1. Do you have an Operations Plan?	☐	Yes	☐	No
2. Are operational and medical protocols included in the Operations Plan?	☐	Yes	☐	No
3. What was the effective date of your Operations Plan?				
4. **Please provide a map of the coverage area for your service.**				

Service Name:	
	(EMS Service)

QUALITY ASSURANCE REVIEW

1. Do you have an internal quality assurance/improvement mechanism in place? ☐ Yes ☐ No

   If "Yes", please attach description.

2. Indicate the dates of this year's quality assurance review activities.

   Reviews are conducted: ☐ Daily ☐ Weekly ☐ Monthly ☐ Quarterly ☐ Annually

DATES OF REVIEW

DATE	DATE	DATE	DATE	DATE

SERVICE DIRECTOR/CHIEF

Name:					
	(Name)		*(Title)*		
Address:					
	(Street/Mailing)		*(City)*	*(State)*	*(Zip)*
(Work Phone)	*(Home Phone #)*	*(Pager #)*	*(Cellular Phone #)*	*(E-mail Address)*	
Signature:					

SERVICE MEDICAL DIRECTOR

Name:					
	(Name)		*(Title)*	*(License #)*	
Address:					
	(Street/Mailing)		*(City)*	*(State)*	*(Zip)*
(Work Phone)	*(Home Phone #)*	*(Pager #)*	*(Cellular Phone #)*	*(E-mail Address)*	

**In signing this application I am certifying that I am actively providing medical direction for this EMS Service.*

****Signature:***	

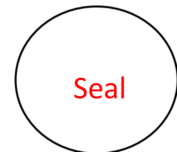
SERVICE TRAINING COORDINATOR

Name:					
	(Name)	*(Title)*	*(License #)*	*(Level)*	
Address:					
	(Street/Mailing	*(City)*	*(State)*	*(Zip)*	
(Work Phone)	*(Home Phone #)*	*(Pager #)*	*(Cellular Phone #)*	*(E-mail Address)*	
Signature:					

Service Name:	
	(EMS Service)

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

The above was sworn and subscribed to before this Day of , 20



Notary Public

My Commission Expires

****** Notary is for the person completing form**