



Southern Region EMS Council, Inc. Code Blue EMS Equipment Request Form



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| EMS Agency Name: | Contact Person: | Email Address: |
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|------------------|----------------------------|---------------|-------------|
| Mailing Address: | Physical Shipping Address: | Phone Number: | Fax Number: |
|------------------|----------------------------|---------------|-------------|

PLEASE TYPE OR PRINT CLEARLY - ONE ITEM PER FORM - INCOMPLETE FORMS WILL NOT BE ACCEPTED

| Priority | Equipment Description | Cost | Quantity | Shipping | Model | Total Cost w/ shipping | Portential Vendor |
|----------|-----------------------|------|----------|----------|-------|---------------------------|-------------------|
| | | | | | | | |

| Cash Match Amount | Guaranteed By Whom | Match Letter Included |
|-------------------|--------------------|---|
| | | A letter guaranteeing the cash match *MUST* be submitted with this request form. |

| Justification (Patient Transport Vehicle requests must include complete shipping plan and estimate. Attach additional sheets as needed) | New or Replaced Equipment? | | |
|---|--|-----|-------------|
| | <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;">New</td> <td style="width: 50%; border: none;">Replacement</td> </tr> </table> | New | Replacement |
| New | Replacement | | |

| Maintenance Plan (Attach additional sheet if needed) |
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| | |
| Signature & Printed Name of EMS Agency Representative | Date |

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| | |
| Signature & Printed Name of Local EMS Medical Director | Date |

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| | |
| Signature & Printed Name of Subarea Coordinator | Date |

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| Signature & Printed Name of Regional EMS Director | Date |