

EMS COUNTY GRANT APPLICATION

**FLORIDA DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services**

Complete all items

ID. Code (The State Bureau of EMS will assign the ID Code – leave this blank) C _____

1. County Name:
Business Address:
Telephone:
Federal Tax ID Number (Nine Digit Number). VF _____

2. Certification: (The applicant signatory who has authority to sign contracts, grants, and other legal documents for the county) I certify that all information and data in this EMS county grant application and its attachments are true and correct. My signature acknowledges and assures that the County shall comply fully with the conditions outlined in the Florida EMS County Grant Application.	
Signature:	Date:
Printed Name:	
Position Title:	

3. Contact Person: (The individual with direct knowledge of the project on a day-to-day basis and has responsibility for the implementation of the grant activities. This person is authorized to sign project reports and may request project changes. The signer and the contact person may be the same.)	
Name:	
Position Title:	
Address:	
Telephone:	Fax Number:
E-mail Address:	

4. Resolution: Attach a current resolution from the Board of County Commissioners certifying the grant funds will improve and expand the county pre-hospital EMS system and will not be used to supplant current levels of county expenditures.
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5. Budget: Complete a budget page(s) for each organization to which you shall provide funds. List the organization(s) below. (Use additional pages if necessary)

