

FLORIDA DEPARTMENT OF HEALTH  
EMS GRANT PROGRAM

**REQUEST FOR GRANT FUND DISTRIBUTION**

In accordance with the provisions of Section 401.113(2)(b), F. S., the undersigned hereby requests an EMS grant fund distribution for the improvement and expansion or continuation of pre-hospital EMS.

**DOH Remit Payment To:**

Name of Agency: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

\_\_\_\_\_

Federal Identification Number \_\_\_\_\_

Authorized Agency Official: \_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Type Name and Title

*Sign and return this page with your application to:*

*Florida Department of Health  
BEMS Grant Program  
4052 Bald Cypress Way, Bin C18  
Tallahassee, Florida 32399-1738*

**Do not write below this line. For use by Bureau of Emergency Medical Services personnel only**

Grant Amount For State To Pay: \$ \_\_\_\_\_ Grant ID Code: \_\_\_\_\_

Approved By: \_\_\_\_\_  
Signature of EMS Grant Officer Date

State Fiscal Year: \_\_\_\_\_ - \_\_\_\_\_

Organization Code      E.O.      OCA      Object Code  
64-42-10-00-000                     750000

Federal Tax ID:      VF \_\_\_\_\_

Grant Beginning Date: \_\_\_\_\_ Grant Ending Date: \_\_\_\_\_