Georgia Trauma Commission
Right Patient, Right Hospital, Right Time, Right Means

GEORGIA TRAUMA COMMISSION EMS TRAUMA RELATED EQUIPMENT GRANT APPLICATION FORM			
Name of Grant: FY 2017 GTC EMS Trauma Related Equipment Grant Program			
Applying Organization Legal Name:			
Doing Business As "DBA" (if differs from Legal Name):			
Physical Address (No PO Box):			
City:	**State:**	**ZIP Code:**	**County:**
Phone:	**Fax:**	**E-mail:**	
Federal Tax ID Number:			
GA EMS Provider License Number:			
DIRECTOR OF APPLYING ORGANIZATION			
Name/Title:			
Physical Address (No PO Box):			
City:	**State:**	**ZIP Code:**	
Phone:	**E-mail:**		
FISCAL OFFICER OF APPLYING ORGANIZATION			
Name/Title:			
Physical Address (No PO Box):			
City:	**State:**	**ZIP Code:**	
Phone:	**E-mail:**		
OPERATING ORGANIZATION (entity that would receive award. If different from Applying Organization, if not different leave blank.)			
Name:			
Physical Address (No PO Box):			
City:	**State:**	**ZIP Code:**	
Phone:	**E-Mail:**		
Federal Tax ID Number:			
CONTACT PERSON FOR OPERATING ORGANIZATION (If Different from Applying Organization Director)			
Name/Title:			
Physical Address (No PO Box):			
City:	**State:**	**ZIP Code:**	
Phone:	**E-mail:**		

This Document is to be completed, printed, signed and submitted as part of the Application Packet. EACH QUESTION MUST BE ANSWERED.

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GEORGIA TRAUMA COMMISSION EMS TRAUMA RELATED EQUIPMENT GRANT APPLICATION FORM		
CONTACT PERSON FOR FURTHER INFORMATION ON APPLICATION (If Different from Contact Person for Operating Organization)		
Name/Title:		
Physical Address (No PO Box):		
City:	**State:**	**ZIP Code:**
Phone:	**E-mail:**	

Please answer each question:

QUESTION	ANSWER FIELD
Has Applying Organization been assigned a 911 zone by your EMS Regional Council? If yes, name EMS Regional Council and 911 zone in answer field. If "No" place "No" in answer field.	
What is the name of the predominant county within the 911-zone? Place name of County in answer field.	
How many 911-zoned ambulances does Applying Organization operate within the State of Georgia?	
How many of the 911-zoned ambulances (noted above) does Applying Organization operate within their respective assigned EMS Region?	
Provide in the answer field the name and address of the closest (*closest to the largest city in the 911-zone*) Level I or Level II State-designated Trauma Center (*Georgia, Florida, South Carolina, North Carolina, Tennessee or Alabama*).	
Provide in the answer field the United States Postal Service (USPS) address of the farthest point within your 911-zone to the closest trauma center identified above.	
Using http://maps.google.com/ for calculating mileage, provide in the answer field the distance in miles from the above named trauma center to the above identified farthest point address.	
Is the original signed and notarized affidavit listing and affirming all eight (8) conditions detailed in Attachment B and on Applying Organization's letterhead included in this completed application? Enter "Yes " or "No" in the answer field.	

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Does the Applying Organization understand and agree to comply with the eligible equipment parameters detailed in Attachment D of the grant documents? Enter "Yes " or "No" in the answer field.		
I certify the information contained in the submitted application is true and accurate to the best of my knowledge and that I have submitted this application on the behalf of the Applying Organization.		
SIGNATURE:	**TITLE:**	**DATE:**

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