



**GEORGIA TRAUMA COMMISSION EMS TRAUMA RELATED EQUIPMENT GRANT
APPLICATION FORM**

Name of Grant: AFY 2018 GTC EMS Trauma Related Equipment Grant Program

Applying Organization Legal Name:

Doing Business As "DBA" (if differs from Legal Name):

Mailing Address:

City:	State:	ZIP Code:	County:
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Phone:	Fax:	E-mail:
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Federal Tax ID Number:

GA EMS Provider License Number:

EMS DIRECTOR OF APPLYING ORGANIZATION

Name/Title:

Phone:	E-mail:
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CONTACT PERSON FOR FURTHER INFORMATION ON APPLICATION (If Different from Contact Person(s) listed above)

Name/Title:

Phone:	E-mail:
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Please answer each question:

QUESTION	ANSWER FIELD
Is the original signed and notarized affidavit listing and affirming all seven (7) conditions detailed in Attachment B and on Applying Organization's letterhead included in this completed application? Enter "Yes " or "No" in the answer field.	
Does the Applying Organization understand and agree to comply with the eligible equipment parameters detailed in Attachment B of the grant documents? Enter "Yes " or "No" in the answer field.	
Which county or counties is the Applying Organization requesting funds for?	

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