GEORGIA TRAUMA COMMISSION EMS TRAUMA RELATED EQUIPMENT GRANT APPLICATION FORM			
Name of Grant: FY 2019 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:**
Phone:	**Fax:**	**E-mail:**	
Federal Tax ID Number:			
GA EMS Provider License Number:			
EMS DIRECTOR OF APPLYING ORGANIZATION			
Name/Title:			
Phone:	**E-mail:**		
CONTACT PERSON FOR FURTHER INFORMATION ON APPLICATION (If Different from Contact Person(s) listed above)			
Name/Title:			
Phone:	**E-mail:**		
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:**	

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