Interior Region EMS Council, Inc
Code Blue EMS Equipment Request Form

EMS Agency Name:	Contact Person:	Email Address:

Mailing Address:	Physical Shipping Address:	Phone Number:	Fax Number:

PLEASE TYPE OR PRINT CLEARLY - **ONE ITEM PER FORM** - INCOMPLETE FORMS WILL NOT BE ACCEPTED

Model	Equipment Description	Unit Cost	Quantity	Shipping	Total Cost	*Priority	Quotes Attached? Y/N

Local Match Amount	Guaranteed By Whom	Match Letter Included
		A letter guaranteeing the required local match MUST be submitted with this request form.

Justification (Patient Transport Vehicle requests must include complete shipping plan and estimate. Attach additional sheets as needed)	New or Replaced Equipment?
	New Replacement

Maintenance Plan (Attach additional sheet if needed)

*Signature & Printed Name of EMS Agency Medical Director	*Date
*Signature & Printed Name of SubArea Coordinator	*Date

Signature & Printed Name of EMS Agency Representative	Date
Signature & Printed Name of Regional EMS Director	Date

* Complete this Section if Applicable