CODE BLUE PHASE 19 EQUIPMENT REQUEST FORM

DUE JANUARY 15, 2019

EMS AGENCY NAME:_____ CONTACT PERSON:_____ EMAIL:_____

MAILING ADDRESS	PHYSICAL ADDRESS	CITY, STATE, ZIP CODE	PHONE NUMBER	FAX NUMBER

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

PRIORITY**	EQUIPMENT DESCRIPTION	QTY	MODEL	ESTIMATED PRICE EACH	POTENTIAL VENDOR
				List Estimated Freight Separately	

CASH MATCH AMOUNT	GUARANTEED BY WHOM	MATCH LETTER INCLUDED
$		A letter guaranteeing the required match must be submitted with this request form.

JUSTIFICATION	

SIGNATURE & PRINTED NAME OF EMS AGENCY REPRESENTATIVE DATE SIGNATURE AND PRINTED NAME OF LOCAL EMS MEDICAL DIRECTOR IF APPLICABLE DATE

**: Prioritize your item requests ranking beginning with 1, 2, 3, etc. If all items can't be funded; they will be funded based on the item priority