ATTACHMENT A

GEORGIA TRAUMA COMMISSION

GEORGIA TRAUMA COMMISSION EMS TRAUMA-RELATED EQUIPMENT GRANT APPLICATION FORM			
Name of Grant: FY 2024 EMS GTCNC EMS Trauma Related Equipment Grant			
Applying Organization Legal Name:			
Doing Business As "DBA" (if differs from Legal Name):			
Mailing Address:			
Payment Address*: ***Address must be verified & approved by State of Georgia.***			
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 FOR FURTHER INFORMATION ON APPLICATION (If Different from 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 the Applying Organization's letterhead included in this completed application?	**Yes☐ No☐**
Does the Applying Organization understand and agree to comply with the eligible equipment parameters detailed in Attachment B of the grant documents?	**Yes☐ No☐**
Total number of licensed ambulances for applying organization?	**Total Number: _____**
Number of "peak demand staffed" 911 response ambulances for this 911 zone? ***Peak Demand Staffed: The peak number of ambulances that are scheduled and staffed on a consistent basis.***	**"Peak Demand Staffed" Number:** **_____**
For which county is the Applying Organization requesting funds? ***A separate application is required for each county**	**County: _____**

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 behalf of the Applying Organization.

SIGNATURE:	TITLE:	DATE:

All awarded funds are State Funds.

ATTACHMENT B

"I am the Authorized Agent for _____(Applying Organization). I, _____(print name), do affirm the following listed equipment has been/will be purchased and placed in service. I,_____(print name), agree to the following items listed below (type out all items listed in Attachment B add additional rows if needed)."

Item(s) Purchased	Number of Units Purchased	Cost of Each Unit	Total Cost
Total Cost of All Items Purchased			

1. I am the Authorized Agent for this Ambulance Service. We are the zoned 911 provider in the County we are requesting the grant for. Agree to utilize these grant dollars for trauma-related services with the 911-zone EMS agency described in the application for the grant.

2. Agree that if there is equipment purchased with grant dollars and is to be sold, the Georgia Trauma Commission will approve the disposal before the disposal is affected.

    a. Agree that this equipment will not be used as collateral for a loan beyond the amount of local contribution.
    b. Agree that this equipment will remain titled to the original grantee unless permission is obtained from the Georgia Trauma Commission to reallocate this equipment to another 911-zone EMS Agency.

3. Agree that these grant dollars will not be used to supplant, decrease or reallocate the existing budgeted dollars to the local 911-zoned EMS Response system.

4. Applying organization agrees to participate in the Georgia Trauma Commission-sponsored trauma system development activities. Specifically, for CY 2024-2025, the organization agrees to participate in its respective EMS Region trauma system plan; and all Regional Trauma Advisory Committee meetings.

5. Applying organization agrees it is compliant with the Department of Public Health State Office of EMS data submission requirements. The State Office of EMS will determine compliance.

6. Applying organization agrees to make available, at all reasonable times during FY 2024, the records for inspection or audit by a duly authorized representative appointed by the Commission or the Georgia State Auditor.

7. Applying organization shall preserve and make available its records for a period of five (5) years from the date of final payment under this agreement or for such period (if any) as is required by applicable statue.

AFFIDAVIT OF AUTHORIZED AGENT

Personally appeared before me, the undersigned officer duly authorized to administer oaths, the affiant, after being duly sworn, stated under oath as follows:

1. THAT the affiant is the Authorized Agent for the Applying Organization, is over the age of eighteen years, and has personal knowledge of the facts contained in this Affidavit.
2. THAT the Applying Organization is the zoned 911 provider in the County for which grant funds are requested.
3. THAT the Applying Organization understands that peak staffed 911 response ambulance means the peak number of ambulances that are scheduled and staffed on a consistent basis.

_____ Date: _____
Signature of Affiant

State of Georgia
County of _____
Signed and sworn to (or affirmed) before me on _____
Date
by _____,
Printed name(s) of individual(s) making statement
who proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.
____ Personally Known or
____ Produced Identification
Type of ID _____

_____
Signature of notary public

_____
(Name of notary, typed, stamped or printed)
Notary Public State of Georgia
My commission expires: _____

Stamp/Seal