EMS PROVIDER
REPORT OF EXPENDITURES FY __ (EMS/COUNTY -- 911/1131/3588 Funds)
(A report is needed for each provider)

COUNTY of LICENSURE: ___________________________

Counties of Operation: ____

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Name of EMS Provider: ____

Name of EMS Administrator (Print): ____

Re: Utilization of Funds Received from the Emergency Medical Services (EMS) Trauma Care System Account (911 Funds) and Emergency Medical Services, Trauma Facilities, and Trauma Care Systems Fund (1131 Funds) and Designated Trauma Facilities and Emergency Medical Services Account (3588 Funds)

Total Amount of Allocation this Provider Received: $______________

Purchases/expenditures during period _________________________ - ___________________:
Contract Start Date Contract End Date

<u>RECEIPTS ARE REQUIRED</u>

Supplies: Item: ____________________________________ Cost: $________
Item: ____________________________________ Cost: $________
Item: ____________________________________ Cost: $________
Item: ____________________________________ Cost: $________

Education & Training: Course: ____
Persons Trained: __________________ Date:_________
Cost: $_________

Equipment: Type: _______________________________________ Cost: $_______
Type: _______________________________________ Cost: $_______
Type: _______________________________________ Cost: $_______

Vehicles: Type: _______________________________________ Cost: $_______
Type: _______________________________________ Cost: $_______

Communications Equipment:

Type: ____ Cost: $_______

Type: ____ Cost: $_______

Other Operational Expenditures: ____

____

____

Anticipated Expenditures through August 31, _____, if any: ________________________

Total Cost: $____

Anticipated Expenditures for any funds not expended by August 31. (Not required if entire contract amount is expended by August 31): ______________________________________

Total Cost: $____

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Name of person completing report (Print):_______________________________________

Title:___________________________________ Phone: ___________________________

RAC/County Authorized Signature: ___________________________Title:______________

Name (Print): ____ Date:_________________

*Please attach additional page if necessary.