# 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: _____

_____

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

**RECEIPTS ARE REQUIRED**

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 31st**. (*Not required if entire contract amount is expended by August 31st*): _____

Total Cost: $_____

_____

Name of person completing report (Print):_____

Title:_____ Phone: _____

RAC/County Authorized Signature: _____Title:_____

Name (Print): _____ Date:_____

*Please attach additional page(s) if necessary.