NEW MEXICO DEPARTMENT OF HEALTH

EMS ANNUAL SERVICE REPORT
Fiscal Year 2016
Due Date: January 23, 2015

Submit To:
EMS Bureau
1301 Siler Rd Bldg. F
Santa Fe, NM 87507
Attn: Ann Martinez
505-476-8233

Service Name:	
	(EMS Service)

Mailing Address:					
	(Mailing Address)				
	(City)		*(State)*	*(Zip)*	*(+4)*
Contact Person:					
	(Name)		*(Title)*		
	(Business Phone)	*(Emergency Phone)*	*(Fax)*	*(E-mail Address)*	
Administration:	MCKINLEY COUNTY				
	(County or Municipality)				
	P.O. BOX 5210				
	(Mailing Address)				
	GALLUP		NM	87305	
	(City)		*(State)*	*(Zip)*	*(+4)*
Contact Person:	KENNETH HOFFMAN		EMS CHIEF		
	(Name)		*(Title)*		
	505-863-3839	505-863-1439	MCKCDR@Q.COM		
	(Telephone #)	*(Fax Phone #)*	*(E-mail Address)*		
EMS Region:	**Region I**	**Region II**	**Region III**		

Physical Location of Ambulance/Medical Rescue Facilities				
#1				
Name of Facility:				
	Latitude	*Longitude*		
Street Address:				
	(City)	*(State)*	*(Zip)*	*(+4)*
#2				
Name of Facility:				
	Latitude	*Longitude*		
Street Address:				
	(City)	*(State)*	*(Zip)*	*(+4)*

(Use additional pages as necessary)

Service Name:	
	(EMS Service)

SERVICE INFORMATION

Type of Service *(Must Check Only One)*		Affiliation Type *(Mark Primary Affiliation Only)*	
	Certified **PRC** Ambulance		Private for-profit
	Certified Medical/Rescue Service (Non-transport)		Private non-profit
	Certified Medical/Rescue Service (Transport Capable)		Fire Dept.-based
	Emergency Medical Dispatch Agency		Law Enforcement or Department of Public Safety-based
	Special Event(s) Agency		Clinic-based
	Air Ambulance		Hospital-based
	Other (Please Specify):		County-based
			Municipality-based
PRC Certification #			Tribal
Medical Rescue Certification #			Other (Please Specify) :

# of Years In Operation			

EMS Calls						Local Receiving Hospital(s)
Received By *(Mark One)*		**Dispatched By** *(Mark One)*				REHOBOTH MCKINLEY HOSPITAL
	Basic 911		Ambulance Service		Central Dispatch	GALLUP INDIAN MEDICAL CTR
X	Enhanced 911	X	Fire Department	X	Location of Dispatch:	CROWNPOINT HOSPITAL
	Local Phone		Law Enforcement		2215 BOYD GALLU	

EMERGENCY MEDICAL SERVICES PERSONNEL

LICENSED NUMBER OF PERSONNEL BY TRAINING LEVEL

	Paid (Indicate Part Time/Full Time	Volunteer*		Paid (Indicate Part Time/Full Time)	Volunteer*
EMS First Responder			Emergency Medical Dispatch Instructor		
EMT Basic			Nurse		
EMT Intermediate			Physician		
EMT Paramedic			Driver		
Emergency Medical Dispatcher			Other		

*Volunteer may include those paid by the run or other non-salary arrangement.

LICENSED EMS PERSONNEL

List all personnel who are currently providing pre-hospital care with your service and identify their state certification or licensure levels, state certification or license numbers, and expiration dates. Also, please indicate the completion date of their emergency vehicle operator's course, if applicable. ***(Use additional pages as necessary.)***

Name	Licensure Level	License Number	License Expiration Date	EVOC Course Date	Paid/Volunteer

Service Name:	
	(EMS Service)

Service Name:	
	(EMS Service)

For Ground Ambulance/Medical Rescue Services Only

GROUND AMBULANCE/MEDICAL RESCUE VEHICLE DRIVERS (Non-EMS Personnel)

List all non-EMS personnel who are functioning as drivers for your service, and indicate the date of completion of their Bureau approved vehicle operator's course. Also, indicate any medical training they may have completed, for information purposes only. (Use additional sheets as necessary.)

Name	Driver's License Number	EVOC Course Date	Class of NMDL	Other Medical Training

GROUND AMBULANCE/MEDICAL RESCUE VEHICLES

Enter the total number of each type of vehicle used by your service. ***(Mandatory)***

Type I:		Type IV:	
Type II:		Medical/Rescue:	
Type III:		Other – Explain:	

List all ambulance/medical rescue units, which are currently used by your service to provide patient transportation or first response. Indicate each vehicle's year, make, model, type (I, II, III, IV), license number, date of manufacture, whether two wheel or four wheel drive, patient capacity for supine patients, and the current mileage. ***(Mandatory)***

(Use additional pages as necessary)

Year	Make And Model	Type of Vehicle	License Number	State Assigned EMSCOM Radio Unit Number	Manufacture Date	2WD or 4WD	Transport Patient Capacity	Mileage	Annual Inspection Date

(Please provide a list of all emergency response units in your department (include engines, brush trucks, etc.)

Service Name:	
	(EMS Service)

VEHICLE PREVENTIVE MAINTENANCE PROGRAM								
1. Do you have a Vehicle Preventive Maintenance Program in place?	X	Yes		No				
If "Yes", please attach a copy of your program.								
2. Indicate the frequency of vehicle inspections:		Daily	X	Weekly		Monthly		Quarterly
3. Attach Annual Safety Inspection for all units. **(PRC ONLY)**								

OPERATIONS PLAN				
Please provide information on the Operations Plan for your service.				
1. Do you have an Operations Plan?	X	Yes		No
2. Are operational and medical protocols included in the Operations Plan?	X	Yes		No
3. What was the effective date of your Operations Plan?	**SEPT 2014**			
4. Please provide a map of the coverage area for your service.				

QUALITY ASSURANCE REVIEW									
1. Do you have an internal quality assurance/improvement mechanism in place?	X	Yes		No					
If "Yes", please attach description.									
2. Indicate the dates of this year's quality assurance review activities.									
Reviews are conducted:		Daily		Weekly		Monthly	X	Quarterly		Annually

DATES OF REVIEW

DATE	DATE	DATE	DATE	DATE
1-14-2014	**3-18-2014**	**5-19-2014**	**7-21-2014**	**9-15-2014**
11-17-2014				

SERVICE DIRECTOR/CHIEF				
Name:				
	(Name)		*(Title)*	
Address:				
	(Street/Mailing)	*(City)*	*(State)*	*(Zip)*
(Work Phone)	*(Home Phone #)*	*(Pager #)*	*(Cellular Phone #)*	*(E-mail Address)*
Signature:				

Service Name:	
	(EMS Service)

SERVICE MEDICAL DIRECTOR					
Name:	RICHARD KRUIS		MED DIR		81-246
	(Name)		*(Title)*		*(License #)*
Address:	910 SUSAN DR		GALLUP	NM	87301
	(Street/Mailing)		*(City)*	*(State)*	*(Zip)*
505-722-1000	505-722-5841		505-870-5292	RKRUIS@GMAIL.COM	
(Work Phone)	*(Home Phone #)*	*(Pager #)*	*(Cellular Phone #)*	*(E-mail Address)*	
In signing this application I am certifying that I am actively providing medical direction for this EMS Service.					
Signature:					

SERVICE TRAINING COORDINATOR					
Name:					
	(Name)		*(Title)*	*(License #)*	*(Level)*
Address:					
	(Street/Mailing		*(City)*	*(State)*	*(Zip)*
(Work Phone)	*(Home Phone #)*	*(Pager #)*	*(Cellular Phone #)*	*(E-mail Address)*	
Signature:					

PERSON COMPLETING FORM					
Name:					
	(Name)		*(Title)*		
Address:					
	(Street/Mailing		*(City)*	*(State)*	*(Zip)*
(Work Phone)	*(Home Phone #)*	*(Pager #)*	*(Cellular Phone #)*	*(E-mail Address)*	
Signature:					

The above was sworn and subscribed to before this Day of , 20

Notary Public **My Commission Expires**

Seal

****** Notary is for the person completing form**