NEW MEXICO DEPARTMENT OF HEALTH

EMS ANNUAL SERVICE REPORT
Fiscal Year 2021
Due Date
January 24,2020

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)*	*(Email)*
Administration:				
	(County or Municipality)			
	(Mailing Address)			
	(City)	*(State)*	*(Zip)*	*(+4)*
Contact Person:				
	(Name)		*(Title)*	
	(Phone)	*(Fax)*	*(Email)*	
EMS Region:	☐ **Region I**	☐ **Region II**	☐ **Region III**	

Physical Location of Ambulance/Medical Rescue Facility(s)				
Location #1				
Name of Facility:				
	Latitude		*Longitude*	
Street Address:				
	(City)	*(State)*	*(Zip)*	*(+4)*
Location #2				
Name of Facility:				
	Latitude		*Longitude*	
Street Address:				
	(City)	*(State)*	*(Zip)*	*(+4)*
	(use additional location sheets as needed)			

Service Name:	
	(EMS Service)

SERVICE INFORMATION	
Type of Service ***(Check Only One)***	**Affiliation Type** ***(Check Primary Affiliation Only)***
☐ Certified PRC Ambulance	☐ Private for-profit with County or Municipal contract
☐ **PRC Certification #:**	☐ Private non-profit with County or municipal contract
☐ Certified Medical/Rescue Service (Non-transport)	☐ Fire department based
☐ Certified Medical/Rescue Service (Transport capable)	☐ Law enforcement or Department of Public Safety based
☐ **Medical Rescue Certification #:**	☐ Clinic based
☐ Emergency Medical Dispatch Agency	☐ Hospital based
☐ Special Event(s) Agency	☐ County based
☐ Air Ambulance with County or Municipal contract	☐ Municipality based
☐ Other (please specify):	☐ Tribal
	☐ Other (please specify):
# Years in Operation:	

EMS Calls			Local Receiving Hospital(s)
Received By ***(mark one)***	**Dispatched by** ***(mark one)***		
☐ Basic 911	☐ Ambulance Service	☐ Central Dispatch	
☐ Enhanced 911	☐ Fire Department	☐ Dispatch Location:	
☐ Local phone	☐ Law Enforcement		

EMERGENCY MEDICAL SERVICES PERSONNEL
LICENSED NUMBER OF PERSONNEL BY TRAINING LEVEL

License Level	Paid Indicate # full-time and part-time employees		Volunteer*	License Level	Paid Indicate # full-time and part-time employees		Volunteer*
	FTE	*PTE*			*FTE*	*PTE*	
EMS First Responder				EMD Instructor			
EMT Basic				Nurse			
EMT Intermediate				Physician			
Paramedic				Driver			
Emergency Medical Dispatcher				Other:			

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

Service Name:	
	(EMS Service)

LICENSED EMS PERSONNEL

(use additional personnel sheets as necessary)

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

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, indicate the date of completion of the Bureau approved vehicle operator's course, and indicate any medical training they may have completed.

(Use additional driver sheets as necessary.)

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

GROUND AMBULANCE/MEDICAL RESCUE VEHICLES

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

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

List all ambulance/medical rescue units that are currently used by your service to provide patient transportation or first response. In addition, please provide a list of all emergency response units in your department (engines, brush trucks, etc.)

(Mandatory)

(Use additional vehicle pages as necessary)

Year	Make and Model	Vehicle Type	License Number	State assigned EMSCOM Number	2WD or 4WD	Patient Capacity	Mileage	Annual Inspection Date

Service Name:	
	(EMS Service)

VEHICLE PREVENTATIVE MAINTENANCE PROGRAM

Do you have a vehicle preventative maintenance program in place? ☐ Yes ☐ No

If yes, please attach a copy of your program

Indicate the frequency of vehicle inspections: ☐ Daily ☐ Weekly ☐ Monthly ☐ Quarterly

Attach a copy of your annual safety inspection for all units if you are a PRC certificated service.

OPERATIONS PLAN

Please provide information on the operations plan for your service.

Do you have an operations plan? ☐ Yes ☐ No

Are operational and medical protocols included in the operations plan? ☐ Yes ☐ No

What was the effective date of your operations plan?

Please provide a map of the coverage area for your service

QUALITY ASSURANCE REVIEW

Do you have an internal quality assurance/improvement mechanism in place? ☐ Yes ☐ No

If yes, please attach a brief description.

Indicate the dates of this year's quality assurance review activities.

Reviews are conducted: ☐ Daily ☐ Weekly ☐ Monthly ☐ Quarterly ☐ Annually

DATES OF REVIEWS

DATE	DATE	DATE	DATE	DATE

PEDIATRIC EMERGENCY CARE COORDINATOR (PECC)

RESPONSES TO THE FOLLOWING ARE MANDATORY. FAILURE TO ANSWER WILL RESULT IN AN INCOMPLETE REPORT

A PECC is an individual(s) who is responsible for coordinating pediatric specific activities to include education, training and equipment. NHTSA and HRSA have established benchmarks to have a PECC in 90% of EMS services by 2026.

Which one of the following statements best describes your agency?

- ☐ We have a designated PECC.
- ☐ We do not have a designated PECC.
- ☐ We do not currently have a PECC but have a plan to add this role in the next year.
- ☐ We do not currently have a PECC but would be interested in adding this role.

If you plan to add or are interested in adding a PECC, when would it be implemented:

☐ 6 months ☐ 1 year ☐ 2-3 years ☐ Undetermined

If you indicated that you have a PECC, please provide their contact information:

Name:

Email: Phone:

Service Name:	
	(EMS Service)

SERVICE DIRECTOR/CHIEF					
Name:					
(Name)		*(Title)*			
Address:					
(Street/Mailing)		*(State)*	*(Zip)*	*(+4)*	
(Work Phone)	*(Home Phone)*	*(Cellular Phone)*	*(Email)*		
Signature:					

SERVICE MEDICAL DIRECTOR					
Name:					
(Name)		*(Title)*			
Address:					
(Street/Mailing)		*(State)*	*(Zip)*	*(+4)*	
(Work Phone)	*(Home Phone)*	*(Cellular Phone)*	*(Email)*		
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)*			
Address:					
(Street/Mailing)		*(State)*	*(Zip)*	*(+4)*	
(Work Phone)	*(Home Phone)*	*(Cellular Phone)*	*(Email)*		
Signature:					

PERSON COMPLETING FORM					
Name:					
(Name)		*(Title)*			
Address:					
(Street/Mailing)		*(State)*	*(Zip)*	*(+4)*	
(Work Phone)	*(Home Phone)*	*(Cellular Phone)*	*(Email)*		
Signature:					

STATE OF NEW MEXICO)
)
COUNTY OF _____)

This instrument was acknowledged before me on the _____day of _____, 20
by _____.
(Person completing form)

_____ My commission expires: _____
Notary Public