



KENTUCKY BOARD OF EMERGENCY MEDICAL SERVICES

COMMONWEALTH OF KENTUCKY
2545 LAWRENCEBURG ROAD
FRANKFORT, KENTUCKY 40601
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Honorable Rob Rothenburger
Board Chair

Brian K. Bishop
Executive Director

Kentucky Board of Emergency Medical Services Block Grant Funding Application

Applicant Information:

Applicant/Name of Service Provider County

___ I Am Requesting Ambulance Funding:

Vehicle To Be Acquired: Is the vehicle to be acquired: _____
New Used Demonstrator
\$ _____
Mileage of Vehicle To Be Purchased Manufacturer of Ambulance Conversion Model Year Total Acquisition Cost

Will The Block Grant Funds Be Used To: ___Purchase or ___Lease The Vehicle.

Vehicle To Be Replaced: _____
Manufacturer of Ambulance Conversion Model Year VIN Number

_____ Is the vehicle to be replaced totally inoperable? _____
Vehicle Mileage Yes No

___ I Am Requesting Ambulance Equipment Funding:

Item	Quantity	Cost Per Unit	Total Cost
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

___ I Am Requesting Training Equipment Funding:

Item	Quantity	Cost Per Unit	Total Cost
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____



"An Equal Opportunity Employer M/F/H

___ I Am Requesting Personnel or Medical Director Training Expense Funding:

1. Training To Be Provided: _____

Number Of: Staff To Be Trained:_____ Medical Directors To Be Trained:_____

Total Cost Per Student: _____ Total Expenditure:_____

2. Training To Be Provided: _____

Number Of: Staff To Be Trained:_____ Medical Directors To Be Trained:_____

Total Cost Per Student: _____ Total Expenditure:_____

3. Training To Be Provided: _____

Number Of: Staff To Be Trained:_____ Medical Directors To Be Trained:_____

Total Cost Per Student: _____ Total Expenditure:_____

Will The Funds Allocated Under This Award Be:

___ Expended Within This Fiscal Year; or,

___ Combined With The Award Received In The Next Fiscal Year.

In making application for these funds we hereby swear (or affirm):

That the ambulance service will provide documentation of required expenditures to KBEMS staff upon request.

- That grant funds received by the applicant shall be used only for purposes authorized by KRS 311A.155 and 202 KAR 7:520 and for no other purpose.
- That the information contained in this application is true and correct.

Signature of Ambulance Provider – Applicant

Date Signed

Daytime Telephone Number: _____

Signature of County Judge Executive or Mayor

Date Signed

Daytime Telephone Number: _____

Sworn and subscribed before me this _____ day of _____, 20__

Signature of Notary Public

My Commission Expires