

EMS COUNTY GRANT APPLICATION

**FLORIDA DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services**

Attachment # 1
Page 1 of 3

Complete all items

ID. Code (The State Bureau of EMS will assign the ID Code – leave this blank) **C** _____

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| 1. County Name: Leon County |
| Business Address: Leon County Courthouse |
| 301 South Monroe Street |
| Tallahassee, FL 32301 |
| Telephone: 850-606-1921 |
| Federal Tax ID Number (Nine Digit Number): VF_59-6000708 _____ |

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| 2. Certification: (The applicant signatory who has authority to sign contracts, grants, and other legal documents for the county) I certify that all information and data in this EMS county grant application and its attachments are true and correct. My signature acknowledges and assures that the County shall comply fully with the conditions outlined in the Florida EMS County Grant Application. | |
| Signature: _____ | Date: _____ |
| Printed Name: C.E. DePuy | |
| Position Title: Chairman, Leon County Board of County Commissioners | |

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|--|--------------------------|
| 3. Contact Person: (The individual with direct knowledge of the project on a day-to-day basis and has responsibility for the implementation of the grant activities. This person is authorized to sign project reports and may request project changes. The signer and the contact person may be the same.) | |
| Name: Don Lanham | |
| Position Title: Director of Health & Human Services | |
| Address: 918 Railroad Avenue | |
| Tallahassee, FL 32301 | |
| Telephone: 850-606-1921 | Fax Number: 850-606-1901 |
| E-mail Address: Lanhamd@Leoncountyfl.gov | |

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| 4. Resolution: Attach a current resolution from the Board of County Commissioners certifying the grant funds will improve and expand the county pre-hospital EMS system and will not be used to supplant current levels of county expenditures. |
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| 5. Budget: Complete a budget page(s) for each organization to which you shall provide funds. List the organization(s) below. (Use additional pages if necessary) |
| Leon County Emergency Medical Services Division |
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REQUEST FOR GRANT FUND DISTRIBUTION

In accordance with the provisions of Section 401.113(2)(a), F. S., the undersigned hereby requests an EMS grant fund distribution for the improvement and expansion of pre-hospital EMS.

DOH Remit Payment To:

Name of Agency: Leon County

Mailing Address: 301 South Monroe Street
Tallahassee, FL 32301

Federal Identification number 59-6000708

Authorized Official:

Signature

Date

C. E. DePuy, Chairman Leon County Board of County Commissioners
Type Name and Title

Sign and return this page with your application to:

*Florida Department of Health
BEMS Grant Program
4052 Bald Cypress Way, Bin C18
Tallahassee, Florida 32399-1738*

Do not write below this line. For use by Bureau of Emergency Medical Services personnel only

Grant Amount For State To Pay: \$ _____ Grant ID: Code: _____

Approved By :

Signature of EMS Grant Officer Date

State Fiscal Year: -

Organization Code E.O. OCA Object Code
64-42-10-00-000 CG N2000 750000

Federal Tax ID: VF _____

Grant Beginning Date: October 1, _____ Grant Ending Date: September 30, _____

DH Form 1767P, Rev. June 2002