FLORIDA DEPARTMENT OF HEALTH
EMS GRANT PROGRAM

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: Miami-Dade County Board of County Commissioners
Mailing Address: 111 NW 1 Street, 26 floor, Finance Department
Miami, Fl. 33128

Federal Identification number #596-00-0573

Authorized Official: _____ 10/18/12
Signature Date

Genaro "Chip Iglesias
Chief of Staff/Deputy Mayor
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	Category
64-42-10-00-000	05	SF005	750000	059998

Federal Tax ID: VF _ _ _ _ _ _ _ _ _

Grant Beginning Date: _____ Grant Ending Date: _____