

CURRENT SERVICE CREDIT CLAIM FORM

*Cooper/Sams Volunteer Ambulance Incentive Award Program
 Application for period of July 1, 2015 - June 30, 2016*

INSTRUCTIONS: The information supplied is for internal use by the EMSRB. You are not legally required to provide all the information, but if you choose not to we will be unable to calculate the incentive credits for your application.

Ambulance Service Information:

1. Provide name of ambulance service.
2. Provide EMSRB license number of ambulance service.
3. Provide complete address of ambulance service.
4. Provide contact e-mail address

Personnel Information:

1. Provide personnel names - last, first, middle.
2. Provide personnel EMSRB - ID (Certification/Registration Number)
3. Provide personnel Date of Birth (DOB).
4. Indicate Registration, Certification or Licensure level: (FR/EMR; EMT; RN; MD; Driver Only)

Signatures and Notary: The affidavit on the last page of this form must be signed by the chief administrative officer of the ambulance service and notarized.

Submission Deadlines: *The completed and signed forms must be sent to the EMSRB at the above address by US Mail with a postmark no later than **August 1, 2016**.*

Ambulance Service Recordkeeping: Ambulance service should maintain a copy of information submitted for their records and personnel information.

Confirmation of Receipt: Within 2 weeks the EMSRB will e-mail the ambulance service confirming receipt of forms for current service credit claims. If you do not receive the confirmation e-mail, please contact our office at 651-201-2800 or 800-747-2011.

Ambulance Service Information

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|--|-------------------------------------|
| 1. Ambulance Service Name | 2. Ambulance Service License Number |
| 3. Address (Street, City, State, Zip Code) | |
| 4. Contact e-mail address | 5. Telephone Number |

*I certify that within the time period beginning July 1, 2015 and ending June 30, 2016, the following people provided services as a volunteer ambulance employee and met the ambulance income limit of **\$7,491.00**. The information I have provided on this form is true and correct to the best of my knowledge.*

Personnel Information

	1. Name: Last, First, Middle (please alphabetize the list)	2. EMSRB - ID	3. DOB	4. Level: FR/EMR; EMT; RN; MD; Driver Only
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Ambulance Service Name: _____

	1. Name: Last, First, Middle (please alphabetize the list)	2. EMSRB - ID	3. DOB	4. Level: FR/EMR; EMT; RN; MD; Driver Only
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Signatures and Notary:

<p>STATE OF MINNESOTA)</p> <p>County of _____)</p> <p>_____, being first duly sworn, attest that to the best of the affiant's knowledge (Name of chief administrative officer) and belief, the personnel named above, who are claiming credit for volunteer ambulance service, did, within the time period beginning July 1, 2015 and ending June 30, 2016, provide services as a volunteer ambulance employee; met the \$7,491.00, income limit for that period as defined in Minnesota Statutes 144E.41; and complied with the qualified ambulance service personnel requirements of Minnesota Statutes 144E.41. Further, affiant the information on this form is true and correct to the best of the affiant's ability. Further, affiant sayeth not.</p> <p>_____ Chief Administrative Officer Signature</p> <p>_____ Notary Public Signature</p> <p>Subscribed and sworn before me this ____ day of _____, 20____.</p>	<p>Affidavit of Ambulance Service</p>
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Reminders:

- Maintain a copy of the completed document for ambulance service records.
- Submission Deadline is **August 1, 2016**.

Ambulance Service Name: _____

Please use this page for additional personnel if necessary.

	1. Name: Last, First, Middle (please alphabetize the list)	2. EMSRB - ID	3. DOB	4. Level: FR/EMR; EMT; RN; MD; Driver Only
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