Affirmation

(required for all grant submissions)

Kansas Board of Emergency Medical Services, 900 S.W. Jackson, Room 1031, Topeka, KS 66612

The agency owner/operator, service director, and medical director, whose names and original signatures appear below have been designated by the agency to complete and submit a grant request on its behalf. The agency agrees to comply with the rules and regulations governing financial assistance from the Kansas Board of Emergency Medical Services for Revolving and Assistance Fund requests. In addition, the agency owner/operator and service director attest to the agency's ability to provide the matching funds (if required) to complete the purchase of the equipment, should they be awarded state funds. The agency owner/operator and service director are aware that equipment purchased with state monies must be purchased without any financial liens and without the item being used as collateral to secure a loan of any kind. The agency owner/operator and service director, by signing below, attest to the fact that the agency(s) that is affected by the possible outcome of this grant request have been notified and agree to its submission. The agency owner/operator and service director, by signing below, attest that to the best of his/her knowledge, the information contained herein with regard to the agency's financial condition is true and accurate. The medical director, by signing below, attests that he/she is aware of this request and will ensure the service's providers are sufficiently trained on any medical equipment purchased with KRAF grant funds. ***The agency owner/operator, service director, and medical director signatures are required in order for this application to be considered complete.***

Request for Federal/Employer Identification Number (required)

Business Name (as shown on your income tax return)

Business name, if different from above (Doing Business As (DBA))

Address (number, street, and/or suite no. per FIN)

City, State, and Zip code

Employer/Federal Identification Number

	Agency Owner/Operator	Service Director	Medical Director
Name:			
Title:			
Phone:			
E-Mail:			
Signature:			

Point of Contact for Grant Management:

Name: **Agency:**

Phone: **Email:**

Application Date:

Brief Project Description: