Kansas Board of Emergency Medical Services

900 S.W. Jackson, Suite 1031, Topeka, Kansas 66612
(785) 296-7296 FAX: (785) 296-6212

New Vendor Product Request Form CY 2024

Complete and return original documents, and retain a copy for your records

An applicant must fill out the form below (in its entirety, with original signatures) to initiate the purchase of **EACH** item/equipment outside of those quotes provided with the grant. Applicant must also provide the vendor quote on vendor letterhead. Accessories must be broken out separately.

Please email request and quote to: kraf@ks.gov. Please provide on the Subject Line: Service name and individual submitting document.

As a grantee under the terms of the Kansas Board of Emergency Medical Service Revolving and Assistance Fund (KRAF) Grant Program the undersigned hereby agrees to provide the following information for a New Vendor Product Request:

Vendor Information	
Company Name (Vendor)	
Address	
Daytime Phone No.	
E-mail address (if available)	
License Service Name	
Address	
Daytime Phone No.	
E-mail address (if available)	
Signature of Service Director **Signature of Operator**	Print:_____ Signature:_____ Print:_____ Signature:_____
Federal Identification Number (FIN)	
Grant Number **(KBEMS Only)**	
Date Executed **(KBEMS Only)**	

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Product Request Form (for each item/equipment)	
Request Date	
Licensed Service	Name:_____ Service Number_____ County:_____
Company Name (Vendor) Vendor Part Number	_____ _____
Item Description	
Quote Price **Quote must be valid for at least 6 months**.	$_____
Vendor Lead Time	
Grant Number **(KBEMS Only)**	
Date Executed **(KBEMS Only)**	