ARROWHEAD EMS ASSOCIATION
REIMBURSEMENT FORM
-Please Complete Top Half Only-

July 2016

Date Submitted: ___________________________

Agency:			
Contact Name:			
Address		City, State	
		Zip	
Phone:		E-mail	

The following items must be included with a request for reimbursement:

Pre-Hospital Providers Communications Equipment

- ☐ A copy of the invoice for communications equipment **(purchased within July 1, 2016 to May 31, 2017)**
- ☐ A copy of **proof of payment** from vendor or a copy of check payment to vendor
- ☐ Completed feedback survey below

Does your agency have a communications equipment replacement schedule? ☐ *Yes* ☐ *No*

Feedback Survey (Required)

Please provide information on how this reimbursement benefits your agency to help us assess communications needs and improve future reimbursement opportunities. *(agency benefits, financial impact, patient care, transmission and reception, equipment performance, other)*

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Please feel free to continue reporting on the backside of this form or attach a document.

REIMBURSEMENT AMOUNT REQUESTED: $ ______________________ (not to exceed $400.00)

Send form and documentation to: **Arrowhead EMS Association**
4219 Enterprise Circle
Duluth, MN 55811
Fax 218-726-0073

Bottom section for AEMSA staff only

PURCHASE REQUISITION

FY 2017 Seatbelt Funds
Pre-Hospital Provider Communications Equipment

Mail by:	
Mailed on:	
Check #	
ED Approval	

Vendor ID #:		Date:		Due:	

Item Description	Account #	Amount
Communications Equipment Reimbursement	52114	