



# SAEMS

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## SOUTHEAST ARIZONA EMERGENCY MEDICAL SERVICES COUNCIL

DAN SPAITE, MD; CHAIR    BILL MILLER, CHIEF FRY FIRE; VICE CHAIR  
TAYLOR PAYSON, MBA, CEP; EXECUTIVE DIRECTOR

**In conjunction with the 2009-2010 provider grants program, the region must also update its annual needs assessment. Please take the time to fill out this questionnaire, even if you prefer not to apply for grant funding. Please return this form, by mail or fax, to the SAEMS office by May 1, 2008. Thank you.**

**AGENCY** \_\_\_\_\_

**CONTACT PERSON** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_

**CITY/ZIP** \_\_\_\_\_

**PHONE/FAX NO'S.** \_\_\_\_\_

**EMAIL OR WEB ADDRESS** \_\_\_\_\_

**1. Indicate the type of area your agency serves:**

- A. **Densely urban (service population: greater than 250,000)**
- B. **Urban (service population: between 100, 000 and 250,000)**
- C. **Suburban (service population: between 40,000 and 100,000)**
- D. **Semi-rural (service population: between 10,000 and 40,000)**
- E. **Rural-remote (service area less than 10,000)**

**2. Indicate primary type of service/provider**

- A. **Ambulance (ground or air)**
- B. **Rescue Service (paid or volunteer)**
- C. **Fire Department/District – 1<sup>st</sup> responder only**
- D. **Fire Department/District with transport service-**
- E. **Base Hospital**
- F. **Receiving facility**

**3. For Transport agencies- Please indicate number of certified personnel in each of the following categories:**

- A. **EMT-B** \_\_\_\_\_
- B. **EMT-I** \_\_\_\_\_
- C. **EMT-P (CEP)** \_\_\_\_\_
- D. **NURSES (for transport agencies only)** \_\_\_\_\_

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**PMB 321; 6890 E. SUNRISE DR.; TUCSON, AZ 85750**

**520-529-1450**

**520-529-2369 FAX**

**[WWW.SAEMS.NET](http://WWW.SAEMS.NET)**

4. What are your greatest training needs? (Please mark 1, 2, or 3 in order of importance)

- A. Recertification classes \_\_\_\_\_
- B. New Paramedic Classes \_\_\_\_\_
- C. New Basic EMT Classes \_\_\_\_\_
- D. Other (please list) \_\_\_\_\_

5. What EMS equipment does your agency need?

- A. in the short term (2 years or less) \_\_\_\_\_
- B. 2-5 years \_\_\_\_\_
- C. Greater than 5 years \_\_\_\_\_

6. What pediatric equipment does your agency need?

- A. in the short term (2 years or less) \_\_\_\_\_
- B. 2-5 years \_\_\_\_\_
- C. Greater than 5 years \_\_\_\_\_

7. What pediatric training does your agency need?-

\_\_\_\_\_

8. Please indicate your level of importance from NA (not applicable), 1 (little importance) to 5 (critical importance) on the following issues:

A. Training opportunities in your area	NA	1	2	3	4	5
B. Difficulty in recruiting/retaining staff	NA	1	2	3	4	5
C. Communications	NA	1	2	3	4	5
D. Hospital diversion/delays in admitting patients	NA	1	2	3	4	5
E. Medicare/insurance reimbursement rules	NA	1	2	3	4	5
F. Age of equipment	NA	1	2	3	4	5
G. Air Medical Transport	NA	1	2	3	4	5
H. Cost of training classes	NA	1	2	3	4	5

Include completed survey with provider grants application or mail or fax to the SAEMS office