



A Tradition of Stewardship
A Commitment to Service

Richie's Fund Application

APPLICANT INFORMATION Hospital Physician Pre-Hospital Care Other Napa County Service Provider: Yes No

Name of Agency or Institution		Date	
Address		City / Zip	
Contact Person's Name		Title	
Email Address		Phone	

REQUESTED ITEMS. Please complete the appropriate section(s) below following criteria provided.

CATEGORY 1: EQUIPMENT REQUESTS: Requests must pertain to pediatric trauma and/or pediatric emergency medical services.

Item #	Name	Description / Justification	Qty	Cost each	Total	County Use Section
1.				\$	\$	Approved: <input type="checkbox"/> Y <input type="checkbox"/> N
2.				\$	\$	Approved: <input type="checkbox"/> Y <input type="checkbox"/> N
3.				\$	\$	Approved: <input type="checkbox"/> Y <input type="checkbox"/> N
4.				\$	\$	Approved: <input type="checkbox"/> Y <input type="checkbox"/> N
5.				\$	\$	Approved: <input type="checkbox"/> Y <input type="checkbox"/> N
Comments:						List approvable items:

CATEGORY 2: SERVICE REQUESTS: Requests must pertain to pediatric trauma and/or pediatric emergency medical services, contain clear deliverables and include an end date. Requests for salary, personnel, or funding to cover ongoing costs will not be considered.

Item #	Description / Justification	Qty	Cost each	Total	County Use Section
1.			\$	\$	Approved: <input type="checkbox"/> Y <input type="checkbox"/> N
2.			\$	\$	Approved: <input type="checkbox"/> Y <input type="checkbox"/> N
Comments:					List approvable items:



REQUEST DESCRIPTION / JUSTIFICATION:

Description (100 words maximum)

Pediatric Connection (100 words maximum)

Cost Breakdown

Service Request Deliverables

Time Frame

Office Use Only

Recommended by EMCC: Yes No

Date:

Approved by Health Officer (signature):

Date: