



EMS SYSTEMS GRANT/SITE SURVEY REIMBURSEMENT

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF EMERGENCY MEDICAL SYSTEMS
SFN 53690 (02/2021)



Submit a separate reimbursement form for each site visit. Payment will be made to the hospital, not the individuals listed. The completed form along with any additional application requirements must be submitted to the Division within five days of site survey completion.

SURVEY INFORMATION

| | | | |
|------------------|-------------------|--------|--------|
| Type of Survey | Cardiac | Stroke | Trauma |
| Application Date | Hospital Surveyed | | |
| Survey Date | Location | | |


REQUESTED REIMBURSEMENT EXPENSES

| | | | | |
|----------------------------|----------------------------------|-----------|-------|--------|
| Check Appropriate Box(es): | Mileage (Total miles _____) | | | |
| Name | \$800 Physician reviewer on-site | Breakfast | Lunch | Dinner |
| Name | \$500 Nurse reviewer on-site | Breakfast | Lunch | Dinner |
| Name | \$400 Physician reviewer virtual | Breakfast | Lunch | Dinner |
| Name | \$250 Nurse reviewer virtual | Breakfast | Lunch | Dinner |

Upon completion of a site visit survey using the expert assistance of a physician or RN as checked above, the hospital listed below has met the eligibility requirements of the Training Grant Funds Distribution - Site Survey Policy of the Division of Emergency Medical Systems.

HOSPITAL INFORMATION

| | | | |
|-------------------------|------------------------------|------------|----------|
| Hospital | Hospital EIN (Tax ID number) | | |
| Street Address / PO Box | City | State | ZIP Code |
| Email | Telephone Number | Fax Number | |
| Authorized Signature | Title | | |

| | | |
|--|---------------------------------------|----------|
|  Division of Emergency Medical Systems ND Department of Health 1720 Burlington Dr Bismarck ND 58504-7736 - OR - dems@nd.gov | DEMS USE ONLY | |
| | Approved for Payment: 6631-HL1259-03 | |
| | Physician reviewer on-site | \$800.00 |
| | Nurse reviewer on-site | \$500.00 |
| | Physician reviewer virtual | \$400.00 |
| | Nurse reviewer virtual | \$250.00 |
| | Breakfast (____x \$7.50) | \$_____ |
| | Lunch (____x \$10.50) | \$_____ |
| | Dinner (____x \$17.50) | \$_____ |
| | Travel (____miles x \$0.____per mile) | \$_____ |
| Total \$_____ | | |

Site survey reimbursement forms must receive appropriate system coordinator approval as well as division director approval prior to being sent for payment processing.

DEPARTMENT APPROVALS

| | | | |
|--------------|------|--------------|------|
| Name (Print) | | Name (Print) | |
| Name | Date | Name | Date |
| Title | | Title | |



Division of Emergency Medical Systems
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