Emergency Physician Fund

MEDICAL TRANSPORT COMPENSATION (MTC)

4742 N. 24th Street, Suite 300, Phoenix, AZ 85016
Ph: (888) 462-8833 Email: taap@EmergencyPhysicianFund.com
Web: EmergencyPhysicianFund.com

APPLICATION FORM

Once completed, email application to taap@emergencyphysicianfund.com

ETF USE ONLY
DATE RECEIVED STAMP

1. COMPANY NAME	**2. FEDERAL TAX ID NUMBER**
3. STREET ADDRESS	**4. MAILING ADDRESS (IF DIFFERENT)**
CITY, STATE & ZIP CODE	**CITY, STATE & ZIP CODE**
5. CONTACT NAME & TITLE	**6. PHONE NUMBER**
7. EMAIL ADDRESS	**8. FAX NUMBER**

9. STATES YOU ARE LICENSED	**10 STATES YOU HAVE 911 CONTRACTS**
11. GROUND TRANSPORT SERVICE AVAILABLE ☐ YES ☐ NO	**12. NUMBER OF PATIENTS PROVIDED GROUND TRANSPORTATION**
13. HELICOPTER TRANSPORT SERVICE AVAILABLE ☐ YES ☐ NO	**14. IF SO, WHAT STATES**

15. NUMBER OF TRAUMA PATIENTS TRANSPORTED IN LAST 12 MONTHS **GROUND**	**16. NUMBER OF TRAUMA PATIENTS TRANSPORTED IN LAST 12 MONTHS** **AIR**	**17. AMOUNT OF UNREIMBURSED, BAD DEBT FOR PREVIOUS YEAR –** **GROUND**	**18. AMOUNT OF UNREIMBURSED, BAD DEBT FOR YEAR TO DATE –** **GROUND**
19. AMOUNT OF UNREIMBURSED, BAD DEBT YEAR TO DATE		**20. AMOUNT OF UNREIMBURSED, BAD DEBT FOR PREVIOUS YEAR -** **AIR**	**21. AMOUNT OF UNREIMBURSED, BAD DEBT YEAR TO DATE -** **AIR**

22. STATEMENT OF NEED - IN THE SPACE BELOW, PLEASE WRITE A BRIEF STATEMENT DESCRIBING NEED FOR ADDITIONAL EMS / TRAUMA FUNDING

I, THE UNDERSIGNED, DO HEREBY ATTEST THAT THE INFORMATION CONTAINED WITHIN THIS APPLICATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT MY APPLICATION WILL BE DISQUALIFIED SHOULD FALSIFIED INFORMATION BE REVEALED.

PRINTED NAME	**TITLE**
SIGNATURE	**DATE**