



**Emergency
Physician
Fund**

TRAFFIC ACCIDENT ASSISTANCE PROGRAM (TAAP)

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Web: EmergencyPhysicianFund.com

APPLICATION FORM

Once completed, email application to taap@emergencyphysicianfund.com

TAAP USE ONLY
DATE RECEIVED STAMP

1. PHYSICIAN NAME	2. LICENSE 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. SPECIALTY (MARK ALL THAT APPLY)

<input type="checkbox"/> TRAUMA / EMERGENCY	<input type="checkbox"/> ORTHOPEDIC	<input type="checkbox"/> ANESTHESIA
<input type="checkbox"/> GENERAL	<input type="checkbox"/> NEUROSURGEON	<input type="checkbox"/> ORTHOPEDIC SPINE
<input type="checkbox"/> OTHER: _____		

10. SOLE PRACTITIONER <input type="checkbox"/> YES <input type="checkbox"/> NO	11. IF PART OF MEDICAL GROUP, PLEASE PROVIDE THE FOLLOWING NAME OF GROUP _____ NUMBER OF TRAUMA & ER PHYSICIANS _____
12. PERFORM TRAUMA OR ER ON-CALL SERVICES <input type="checkbox"/> YES <input type="checkbox"/> NO	13. IF SO, AT WHAT FACILITIES: 1. _____ 2. _____ 3. _____

14. ESTIMATE OF TRAUMA & ER PATIENTS CARED FOR PREVIOUS FISCAL YEAR	15. ESTIMATE OF TRAUMA & ER PATIENTS CARED FOR YEAR TO DATE	16. PERCENTAGE THAT WERE MEDICAID PREVIOUS FISCAL YEAR %	17. PERCENTAGE OF YOUR PRACTICE THAT IS TRAUMA OR ER CALL %
18. ESTIMATE OF UNINSURED / SELF-PAY TRAUMA & ER CARE FOR LAST 24 MONTHS \$	19. ESTIMATE OF UNREIMBURSED TRAUMA & ER CARE FOR LAST 24 MONTHS \$		

20. STATEMENT OF NEED - IN THE SPACE BELOW, PLEASE WRITE A BRIEF STATEMENT HOW UNREIMBURSED / SELF-PAY TRAUMA CARE HAS AFFECTED YOUR PRACTICE.

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