



**Emergency
Physician
Fund**

MEDICAL TRANSPORT COMPENSATION (MTC)

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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