

MEDICAL TRANSPORT COMPENSATION (MTC) P.O. Box 206, San Marcos, CA 92079

P.O. Box 206, San Marcos, CA 92079 Ph: (888) 776-3729 Fx: (866) 565-2334 Web: EmergencyTraumaFund.com

APPLICATION FORM

ETF USE ONLY
DATE RECEIVED STAM

				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		12. NUMBER OF PATIENTS PROVIDED GROUND TRANSPORTATION		
NO				
13. HELICOPTER TRANSPORT SERVICE AVAILABLE YES NO		14. IF SO, WHAT STATES		
15. NUMBER OF TRAUMA PATIENTS	16. NUMBER OF TRAUMA PATIENTS	17. AMOUNT OF UNI	REIMBURSED,	18. AMOUNT OF UNREIMBURSED, BAD
TRANSPORTED IN LAST 12 MONTHS	TRANSPORTED IN LAST 12 MONTHS	BAD DEBT FOR PRE		DEBT FOR YEAR TO DATE –
GROUND	AIR	GROUND		GROUND
19. AMOUNT OF UNREIMBURSED, BAD DEBT YEAR TO DATE		20. AMOUNT OF UNI BAD DEBT FOR PRE		21. AMOUNT OF UNREIMBURSED, BAD DEBT YEAR TO DATE -
		AIR		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		