Emergency Trauma Fund

EMERGENCY PHYSICIAN COMPENSATION (EPC)

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

APPLICATION FORM

EPC 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)

☐ TRAUMA / EMERGENCY ☐ ORTHOPEDIC ☐ NEUROSURGEON
☐ GENERAL ☐ VASCULAR ☐ OTHER: _____

10. PERFORM TRAUMA OR ON-CALL SERVICES ☐ YES ☐ NO

11. IF SO, AT WHAT FACILITIES:

1. _____
2. _____
3. _____

12. NUMBER OF TRAUMA PATIENTS CARED FOR PREVIOUS FISCAL YEAR	13. NUMBER OF TRAUMA PATIENTS CARED FOR YEAR TO DATE	14. PERCENTAGE THAT WERE MEDICARE PREVIOUS FISCAL YEAR %	15. PERCENTAGE OF YOUR PRACTICE THAT IS TRAUMA CALL %

16. AMOUNT OF UNREIMBURSED / SELF-PAY TRAUMA CARE OF PREVIOUS FISCAL YEAR	17. AMOUNT OF UNREIMBURSED / SELF-PAY TRAUMA CARE YEAR TO DATE
$	$

18. 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

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