**EMERGENCY MEDICAL SERVICES DIVISION**
Dave Ghilarducci, MD, FACEP
Medical Director

TO: Emergency Medical Services Agency
EMS Fund (Maddy Fund – SB476)
471 Fourth Street
Hollister, CA 95023

The attached claim is submitted by the undersigned physician for reimbursement from the Emergency Medical Services Fund (EMSF) for fiscal year _____________. The claim is for emergency medical services rendered in a hospital in San Benito County, and and no payment has been received from any source for the services being claimed.

I acknowledge that I have received a copy of the San Benito County Emergency Medical Services Agency EMSF reimbursement procedures. By submitting claims to the EMSF, I agree to comply fully with the terms and conditions set forth therein. I further acknowledge and understand that the attached claim and the liability to San Benito County EMS Fund are limited based on the availability of funds in the EMSF account.

I hereby certify the following:

1. The attached claim and the information submitted therewith are true, accurate, and complete to the best of my knowledge.
2. No part of any of the claim has heretofore been paid; and
3. The amount claimed is justly due me from the Emergency Medical Services Fund.
4. I am a licensed physician/surgeon and personally provided the emergency medical services claimed.

I declare under penalty of perjury under laws of the State of California that the forgoing is true and correct.

By: ________________________________ Date: ________________________
Physician Signature

____________________________________
Please Print – Name of Physician

***Revised: September 1, 2016***