Print Form

Exhibit A

Received_____

EMERGENCY MEDICAL SERVICES FUND

Provider Enrollment Form

[ ] NEW ENROLLEE [ ] CHANGE EXISTING INFORMATION	RETURN TO: EMS FUND ACCOUNTANT 3313 CHANATE ROAD SANTA ROSA, CA 95404

NOTE: Please type or print. All information must be provided or marked N/A. Provider signature is required.

Provider Name (Last, First, Middle)		Group Name (if applicable)
Practice Location Address		National Provider Identifier Number (NPI)
City State Zip Code		Federal Taxpayer ID or Social Security #
Telephone (with area code)	FAX (with area code)	Primary Specialty
Check Made Payable to:		Name and Title of individual authorized to sign for provider: Title _____
Payment Address		Signature_____
City State Zip Code		Print Name _____

*NOTE: Each location must have a different physician identification number. A separate form must be submitted for each provider office or service location.

Provider Signature

I certify under penalty of perjury that the information supplied on this form is true and correct and I agree to comply with the program requirements as set forth in the Conditions of Participation.

Signature_____ Date _____

To prevent claim rejection or incorrect payment, please notify Sonoma County Department of Health Services (707-565-4898) of any changes to the information provided on this application. The signature of the provider is required on all change of address notifications.