Exhibit B

County of Sonoma Department of Health Services
Emergency Medical Services Fund
List of Patients

Provider Name _____ Claims Due _____
Address _____ Page _____ of _____
Telephone #_____ Practice Location _____

Patient Name Last, First, Middle Initial	**Date of Birth**	**Patient Account No.**	**Amount Billed to EMSF**

I certify under penalty of perjury that all claims are submitted in accordance with the requirements of the County of Sonoma Department of Health Services Emergency Medical Services Fund Conditions of Participation. I understand that any failure to comply with these Conditions of Participation could result in removal from program participation.

_____ _____
Authorized Agent Signature Date

_____
Print Name