SAN MATEO COUNTY EMS FUND
PHYSICIAN CERTIFICATION

I, Dr. _____, certify that, for each claim I submit for services rendered, I have provided the physician services listed on the claim(s) and have not received any compensation from the patient or any third party payor. I understand that I will be reimbursed by the EMS Fund for no more than 50% of San Mateo County's uniform fee schedule.

If I receive payment by the patient(s) or responsible payor(s) after I have received reimbursement from the EMS Fund, I shall notify the San Mateo County Health Services Agency. I understand that my future submission of claims to the EMS Fund will be reduced accordingly in the amount of payment(s) received from patient(s) or responsible payor(s).

I agree to keep and maintain patient(s) records for a period of 3 years from the date that my services were provided. As needed, the County may make an inspection and examination of my books and records during normal working hours pursuant to California Health and Safety Code Sections 1797.98a., 1797.98b and 1797.98c.

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

_____	_____	_____
Signature of Physician	Physician's Specialty	Hospital(s) where services performed
_____	_____	_____
Name of Physician (print)	Date Signed	Billing Agent