



Emergency Trauma Fund

EMERGENCY PHYSICIAN FUND
c/o EMERGENCY TRAUMA FUND
2001 L Street N.W., Suite 500, Washington, DC 20036
Phone and Fax: (888) 462-8833
Email: admin@EmergencyTraumaFund.com
Web: EmergencyTraumaFund.com

Once completed, promptly email or fax to us.

APPLICATION FORM

ETF 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 | ☐ ANESTHESIA |
| ☐ GENERAL | ☐ NEUROSURGEON | ☐ ORTHOPEDIC SPINE |
| ☐ OTHER: _____ | | |

10. SOLE PRACTITIONER ☐ YES ☐ NO		11. IF PART OF MEDICAL GROUP, PLEASE PROVIDE THE FOLLOWING NAME OF GROUP _____ NUMBER OF TRAUMA & ER PHYSICIANS _____	
12. PERFORM TRAUMA OR ER ON-CALL SERVICES ☐ YES ☐ NO		13. IF SO, AT WHAT FACILITIES: 1. _____ 2. _____ 3. _____	
14. ESTIMATE OF TRAUMA & ER PATIENTS CARED FOR PREVIOUS FISCAL YEAR	15. ESTIMATE OF TRAUMA & ER PATIENTS CARED FOR YEAR TO DATE	16. PERCENTAGE THAT WERE MEDICAID PREVIOUS FISCAL YEAR %	17. PERCENTAGE OF YOUR PRACTICE THAT IS TRAUMA OR ER CALL %
18. ESTIMATE OF UNINSURED / SELF-PAY TRAUMA & ER CARE FOR LAST 24 MONTHS \$		19. ESTIMATE OF UNREIMBURSED TRAUMA & ER CARE FOR LAST 24 MONTHS \$	

20. 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