ATTACHMENT B

FRESNO COUNTY
DEPARTMENT OF COMMUNITY HEALTH
EMERGENCY MEDICAL SERVICES UNCOLLECTIBLES REQUEST FORM

AGENCY:_____ **MONTH OF SERVICE:**_____

CK	INCIDENT NUMBER	DATE OF SERVICE	LOCATION OF CALL	# OF PTS	DESTINATION	BASE RATE 107.16	MILES	AMOUNT 3.55	NIGHT 9.88	ER 9.88	O2 9.88	TOTAL AMOUNT
TOTAL												

*TWO OR MORE $37.02 **ONE PERSON $107.16

Agency Authorized Signature:_____ Date:_____