Attestation Statement - Ambulance Crew Members

Name of Patient:_____

Patient Call Number: _____

Date of Service:_____

"I,_____ [printed name] hereby attest that the Patient Care Report (PCR) for the date of service above accurately reflects my signatures and/or notations that I made in my capacity as the treating/transporting _____ [certification level (EMT-B, EMT-I, Paramedic, etc.)]] when I treated and / or transported the above listed patient. I do hearby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability."

_____

Signed Printed Name & Credentials Date

When completed this form must be forwarded to the billing company for inclusion with the patient's medical record. Note that a copy of this form is as valid as the original. The form is valid only for the person signing this form.

NOTES:

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