SACRAMENTO COUNTY EMERGENCY MEDICAL SERVICES AGENCY
EMR Supplement Certification Application

Please disclose all pertinent information and specify date(s), jurisdiction(s), violation(s), and their numbers, outcomes and current status.

Name: _____

Social Security Number: _____

Date: _____Page: _____of_____

Supplemental Information: _____

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I hereby certify that all statements made on or in the connection with this application are true to the best of my knowledge and belief, and I understand and agree that any falsification or omission of material fact may cause forfeiture on my part of all rights to EMR Certification.

Signature: _____ Date: _____