TITLE: **RESCUE/AUTO EXTRICATION INVOICE FORM** EMS Policy No. **3204C**

INVOICE

Invoice Number: 3204C – CAD Incident Number

Fire Department/District: Type Fire Dept/Dist Name

Invoice Date: Click or tap to enter a date.

Customer:
San Joaquin County Emergency Medical Services Agency
505 W Service Rd.
French Camp, Ca 95231

Date of Service: Click or tap to enter a date.
Location of Incident: Type location of Incident
Type of Incident: Choose an item.
CAD Incident No. Type CAD Incident No.
Patient Care Record No. Type PCR No. if applicable

Quantity	Personnel or Equipment	Resource or personnel type	Number of hours	Reimbursement amount
	Choose an item.	Choose an item.		
	Choose an item.	Choose an item.		
	Choose an item.	Choose an item.		
	Choose an item.	Choose an item.		
	Choose an item.	Choose an item.		
	Choose an item.	Choose an item.		
	Choose an item.	Choose an item.		
Total Reimbursement Amount:				

Approved: Signature on file
Medical Director

Signature on file
EMS Administrator

TITLE: **RESCUE/AUTO EXTRICATION INVOICE FORM** EMS Policy No. **3204C**

Please make check payable to:

Attn:Name/Title
Fire Department Name/District
Address
Phone

Scope: This invoice has been submitted and shall be reviewed and paid pursuant to the EMS Policy Nos. 3204 Rescue/Auto Extrication Response and Reimbursement to the Unprotected Area and 3205, Response to EMS Incidents to the Unprotected Area.

Submittal approval signature:_____ Date: _____

EMS Agency Review and Approval/Denial

Date received:_____

EMS Agency Administrator: Approved: ☐ Denied: ☐ Date approved:_____

EMS Agency Administrator signature:_____

Approved: Signature on file
Medical Director

Signature on file
EMS Administrator