SUBJECT: **PHYSICIAN CONFIRMATION OF AGREEMENT TO PURCHASE DRUGS AND MEDICAL SUPPLIES** REFERENCE NO. 701.1

PHYSICIAN CONFIRMATION OF AGREEMENT TO PURCHASE DRUGS AND MEDICAL SUPPLIES

I have agreed to assume responsibility for _____ purchase of drugs, medical devices, and controlled drugs under my medical license and DEA registration number.

Current contact information is:

_____
(Physician's Name - Printed)

_____
(Address)

_____
(Business Telephone and Cellular Phone)

_____
(e-Mail Address)

_____
(California Physicians & Surgeons License Number)

_____
(Physician's Signature and Date)

Please return to:

Department of Health Services
Emergency Medical Services Agency
10100 Pioneer Boulevard, Suite 200
Santa Fe Springs, CA 90670
Attn: Provider Agency Program Manager