



**EMERGENCY MEDICAL
SERVICES AGENCY**
LOS ANGELES COUNTY

**PROVIDER AGENCY DRUG AUTHORIZING 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:

(address)

(business telephone and/or cellular phone)

(e-mail address)

California Physician's & Surgeon's License Number

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