EHEMSS Communication Form

The information requested on this form is necessary to conduct a thorough investigation to clarify certain situations.
This information is privileged and confidential.

Incident Information

Date Report Filed: ____/____/____ **Date of Occurrence:** ____/____/____ **Time of Occurrence:** 1_____

Location of Incident: _____

Type of Incident (check all that apply)

☐Commendation	☐Communication	☐Assessment	☐EMS Provider Related
☐Medications	☐Procedure	☐Injury – Patient	☐Patient Related
☐Equipment Related	☐Deviation from SOP	☐Injury – EMT	☐ED Staff Related

Agencies/Organizations Involved: _____

Receiving Hospital: _____ **EMS Report Number:** _____ **ECRN Log Number:** _____

System Personnel Involved (list all names):_____

Non-EMS System Personnel Involved:_____ **Report Initiated By:** _____

Incident Description:

****EMS PERSONNEL – STOP! – DO NOT WRITE BELOW THIS LINE****

EMS System Review:

Disposition

☐ Commendation	☐ Unfounded	☐Re-education	☐Incident Closed
☐Verbal Warning	☐ Written Warning	☐Suspension	☐Date___/___/___

Signature of EMS System Coordinator: _____ **Date:** ____/____/____

Signature of EMS Medical Director: _____ **Date:** ____/____/____

All information contained herein shall be "Privileged and Confidential under the Illinois Medical Studies Act"