

**UNUSUAL OCCURRENCE REPORT**

**Instructions:** Please fill out this form completely. Use additional sheet(s) if necessary. This form is to be provided to your organization EMS Liaison within seven (7) days of the incident. The organization/hospital Liaison shall complete and submit the report to the EMS Agency within fourteen (14) of receipt. The only exception to this will be a Sentinel event, which means an unexpected occurrence involving death or serious physical or psychological injury, these reports shall be submitted directly to the EMS Agency and immediate notification of the EMS Agency Duty Officer. Forms submitted over thirty (30) days will be reviewed at the discretion of the EMS Agency. Incomplete or missing information may result in delays or inability to review the incident. All information contained in this document is confidential, is part of the continuous quality improvement program (CQI), and will not be disclosed to any entity outside the CQI process.

**TYPE OF OCCURRENCE:**     Communications     Field Operations     Professional Conduct  
 Base Hospital Operations     Protocol Violation     Patient Care     MCI  
 Other, explain on a separate sheet of paper

**PURPOSE OF REPORTING (Only Check One):**

Informational Only – Resolved at the Provider Level     Referral to Provider/Hospital Liaison  
 Referral to EMS Agency     Other, explain on a separate sheet of paper

**PERSON REGISTERING REQUEST**

Name:	Telephone Number:
Agency/Employer:	License/Certification #:
Mailing Address:	

**SUBJECT OF REQUEST**

Name:	Telephone Number:
Address (If Known):	Agency/Employer:
	License/Certification #:
Date and Time of Incident:	Location of Incident:

Explain incident in detail:

(Use Additional Pages if Necessary)

List and attach supporting documents and explain their importance (include copy of PCR):

**UNUSUAL OCCURRENCE REPORT, cont.**

Explain any relationships and/or prior contact with the subject. Explain circumstances:

I certify that all of the preceding information, which I have provided, is true, correct, and complete to the best of my knowledge. I understand that all information contained within this document is confidential and will not be disclosed.

\_\_\_\_\_  
Signature\_\_\_\_\_  
Date**EMS LIAISON INVESTIGATION**  
**EMS LIAISON CONTACT INFORMATION**

Name:

Telephone Number:

Agency/Employer:

License/Certification #:

Mailing Address:

Liaison Investigation:

**EMS LIAISON RESOLUTION/RECOMMENDATIONS – Only Check One**

- |  |  |
|--|--|
| <input type="checkbox"/> Informational Only – Resolved at the Provider Level | <input type="checkbox"/> Referral to Provider/Hospital Liaison       |
| <input type="checkbox"/> Referral to EMS Agency                              | <input type="checkbox"/> Other, explain on a separate sheet of paper |

I certify that all of the preceding information, which I have provided, is true, correct, and complete to the best of my knowledge. I understand that all information contained within this document is confidential and will not be disclosed.

\_\_\_\_\_  
Signature\_\_\_\_\_  
Date