

SAN JOAQUIN COUNTY  
EMERGENCY MEDICAL SERVICES AGENCY

TITLE: **SENTINEL EVENT REPORT FORM**

EMS Policy No. **6101A**

**Instructions:** Please fill out form completely using additional sheets as necessary. Incomplete or omitted information may result in the mitigation of the event being delayed. Contact the EMS Agency Duty Officer in accordance EMS Policy No. 6101 Sentinel Event Reporting Requirements and forward the written reports within 24 hours to the San Joaquin County EMS Agency, 500 West Hospital Road/PO Box 220, French Camp, CA 95231.

**Check all appropriate boxes**

- Refusal or failure to implement Base Hospital orders
- Event resulting in a potential increase to patient morbidity or mortality
- Medication or procedural error(s)
- Incident resulting in termination or resignation of EMS personnel pending investigation for clinical issues
- Violation of EMS Policy or treatment protocol with serious potential for patient harm: Policy #: \_\_\_\_\_
- Other (please specify): \_\_\_\_\_

**PERSON REGISTERING REPORT**

NAME			TELEPHONE NUMBER
ADDRESS (Street Number and Name)			APARTMENT NUMBER
CITY	COUNTY	STATE	ZIP CODE

**SUBJECT OF REPORT**

NAME			
EMPLOYER'S NAME			TELEPHONE NUMBER
ADDRESS (Street Number and Name)			
CITY	COUNTY	STATE	ZIP CODE
DATE and TIME OF INCIDENT:	LOCATION OF INCIDENT:		

1. Explain incident in detail.

2. Attach supporting documents (including PCR) and explain their importance.

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

***I certify under penalty of perjury that all of the preceding information, which I have provided, is true, correct, and complete to the best of my knowledge.***

SIGNATURE	DATE SIGNED
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Sentinel Event Reports are confidential and protected from disclosure by § 1040 of the Evidence Code.