EMS San Joaquin Emergency Medical Services Agency
A Division of Health Care Services

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. Incomplete or missing information may result in delays or inability to review the incident. The organization/hospital Liaison shall complete and submit the report to the EMS Agency within seven (7) days of receipt. This form may be forwarded directly to the EMS Agency if it involves any of the parties mentioned above. Forms must be submitted within thirty (30) days of the incident. All information contained in this document is confidential and is part of the continuous quality improvement program (CQI) and will not be disclosed to any entity outside the CQI process. Forms submitted over thirty (30) days will be reviewed at the discretion of the EMS Agency.

Type of Incident: ☐ Medical ☐ Trauma ☐ Other: Please explain: _____

_____

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)

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UNUSUAL OCCURRENCE REPORT, cont.

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

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:

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UNUSUAL OCCURRENCE REPORT, cont.

EMS LIAISON INVESTIGATION, Cont.

EMS LIAISON RESOLUTION/RECOMMENDATIONS

☐ No Action Required ☐ Remedial Education ☐ Remedial Training ☐ Disciplinary Action Taken by Provider

☐ Referred to other EMS Provider (Provide name) _____

☐ Referred to EMS Agency for review and action ☐ Referred to EMS Agency for information only

☐ Other, explain below:

Explain any action taken below:

_____

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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 AGENCY ONLY

Date Received:_____ Date Closed: _____

_____ _____

EMS Agency Staff: Signature:

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