KITSAP COUNTY EMERGENCY MEDICAL SERVICES AND TRAUMA CARE COUNCIL

Pre-Hospital Care
Unusual Incident Report

Date of Incident: _____ Time of Incident: _____

Name(s), Title(s) & Agency(ies)of Personnel Involved:

_____ _____

_____ _____

Facility Involved: _____

Patient Name: _____

Brief factual description of the incident, including actions taken as a result of the situation (use back of form if needed):

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For EMS Office Use Only

Signature: _____

Title: _____

Agency: _____

Run Report Serial #: _____

Control Physician: _____

Control Hospital: _____