North Region
EMS System

Request For Clarification Form

All information contained within this form is private and confidential pursuant to the Illinois Medical Studies Act and is for official use only.

Incident Information

Date Of Report:	Date Of Incident:	Time Of Incident:

Incident Location:

Type Of Incident (Check All That Apply)

☐	Medications	☐	Procedure	☐	Patient Injury	☐	Other Patient Related
☐	Equipment	☐	SOP Deviation	☐	Provider Injury	☐	E.D. Staff Related
☐	Communication	☐	Assessment / Intervention	☐	Other Provider Related	☐	Other

Agency / Organization Involved: Receiving Hospital:

EMS Report Number: ECRN Log Number:

EMS System Personnel Involved (List All):

Non-EMS System Personnel Involved:

Report Initiated By:

Incident Description / Details

***** STOP*** Do not write below this line. For administrative use only.**

EMS System Review:

Disposition:

☐	Unfounded	☐	Re-Education	☐	Verbal Warning	☐	Written Warning	☐	Suspension

EMS Coordinator Signature:		Date:
EMS Medical Director Signature:		Date: