



AIR MEDICAL SERVICES INCIDENT REPORT FORM

Forward the completed form to the HVREMSCO in the event that there is a deviation from or complication of effective transfer of care from ground EMS to AMS.

Name		Title	
Contact #		e-Mail	
Signature		Date	

Incident Information

Date of Incident:				NYS PCR #	
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Air Medical Service Involved:
Other Agencies/Parties Involved:
Requested By(e.g. EMT, Fire Chief, etc):
Requesting Dispatch Entity:
Location of Incident:
Destination (if known):

Describe Incident: (Attach additional information if necessary)
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Call Times

Time of Incident:				
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AMS Requested:				
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AMS Enroute:				
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AMS Orbiting Scene:				
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Flight Crew Began Care:				
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Patient Loaded on Aircraft:				
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AMS Enroute to Hospital:				
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ETA of AMS Given:	() Minutes
ETA to Hospital by Ground:	() Minutes

For Regional EMS Office Use Only
<u>Date Received:</u>
<u>Reviewed By:</u>