Region 1 Request for Clarification Form

(formerly Unusual Occurrence 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 the apply):

☐ Medications ☐ Procedure ☐ Patient Injury ☐ Other Patient Related

☐ Equipment ☐ SMO/SOP Deviation ☐ Provider Injury ☐ ED 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 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 ☐ Other

Region 1 EMS Coordinator Contacted: ☐ Yes ☐ No Date:

EMS Coordinator Signature: Date:

EMS Medical Director Signature: Date: