



**OSF**<sup>®</sup>

SAINT JAMES - JOHN W. ALBRECHT  
MEDICAL CENTER

**Emergency Medical Services**

***EMS System Review Form***

Date of Occurrence: \_\_\_\_\_ Time of Occurrence: \_\_\_\_\_ Date of Report: \_\_\_\_\_

EMS Service: \_\_\_\_\_ Run Number: \_\_\_\_\_

*Type of Occurrence:*

- |                                                     |                                                    |
|-----------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Variation of EMS Policy    | <input type="checkbox"/> ED/Hospital Staff Related |
| <input type="checkbox"/> Variation of Service SOP's | <input type="checkbox"/> MERCI/Communications      |
| <input type="checkbox"/> Variance in SMO/Protocol   | <input type="checkbox"/> Strength/Kudo Identified  |
| <input type="checkbox"/> Other _____                |                                                    |

*Description of Occurrence:*

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Review of Occurrence:*       EMS Office                       Service

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Recommendations:*

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

*Copies To:*       Service       EMS Office                       PMD                       Files