Maryland EMS Base Station
Quality Management Program
Incident Review Request

Date of Incident: _____

Time of Incident: _____

Patient Name: _____

Medical Record # or EMS ID #_____

Ambulance or Medic Unit Number_____

Details of
Incident_____
_____
_____
_____
_____
_____

Name of Person Making Report:
_____

Title/position: _____

Contact information: _____

Who did you notify at [Hospital name] of your concerns? _____

If you wish to discuss this incident in person, please contact the physician EMS Base Station director or the Registered Nurse EMS Base Station coordinator at [#####].