PHARMACY PRE-HOSPITAL INCIDENT REPORT

Saginaw Valley Medical Control Authority

REPORTING PHARMACY:	NAME OF INDIVIDUAL REPORTING:
DATE:	BOX OR BAG NUMBER:
PREVIOUSLY STOCKED BY:	EMS AGENCY USING BOX OR BAG:

Briefly state the problem(s) encountered, attach a copy of the yellow medication sheet, and a copy of the label on the box. Please add any other information that would assist in the resolution of this problem(s). Be factual and do not include opinions or unsubstantiated remarks.

***PLEASE RETURN COMPLETED FORM TO:

SAGINAW VALLEY MEDICAL CONTROL AUTHORITY
1000 Houghton Ave.
Saginaw, MI 48602

FAX: (989) 583-7941

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Signature of Reporting Individual