Prehospital Provider MCI Critique Form (Policy Addendum 837-F)

Please Complete Following All MCI's And Full Scale Exercises

Send Completed Forms to the S-SV EMS Agency

Mail: 5995 Pacific Street, Rocklin, CA 95677, FAX: (916) 625-1720, or Email – John.Poland@ssvems.com

Reporting Entity Information:

Prehospital provider agency:	
Name/title of person completing this form:	
Phone number:	Email address:

Incident Information: ☐ **Real Event** ☐ **Drill**

County: ☐ Colusa	☐ Butte	☐ Nevada	☐ Placer	☐ Shasta	☐ Siskiyou	☐ Sutter	☐ Tehama	☐ Yuba	
Incident name:				Incident location:					
Incident date:				Incident dispatch time:					
First unit on scene time:				Incident end time (all pts transported):					
Incident Commander (Name & Agency):									
Medical Group Supervisor (Name & Agency):									
Triage Unit Leader (Name & Agency):									
Treatment Unit Leader (Name & Agency):									
Patient Transportation Unit Leader (Name & Agency):									
Triage tags used? ☐ Yes ☐ No				EMS MCI ID vests worn? ☐ Yes ☐ No					
Pt tracking sheets (837-E) used? ☐ Yes ☐ No				Pt tracking sheets (837-E) submitted? ☐ Yes ☐ No					
Number and Type of Patients									
Immediate:	Delayed:	Minor:	Refused:	Deceased:					
Number and Type of Transport Resources									
Ground ambulance:	Air ambulance/rescue:	Bus/other:							
First responder agencies:									
Ground transport agencies:									
Air transport agencies:									

Control Facility (CF) Utilization/Interaction:

Name of CF utilized for patient dispersal:			
CF pre-alert by dispatch or prehospital personnel:	☐ Yes	☐ No	Notification time:
CF notification by on scene prehospital personnel:	☐ Yes	☐ No	Notification time:
Were patient destinations received in a reasonable timeframe:	☐ Yes	☐ No	

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After Action Review Information:

Was an After Action Review completed: ☐ Yes ☐ No AAR date:	
List all agencies involved in the AAR:	

Comments, Issues, Suggestions, and Observations (attach additional documentation if necessary):