	MCI Details/Feedback Form	837-D

REPORTING ENTITY	
Reporting Agency:	Reporting Person:
Telephone:	Email Address:

INCIDENT INFORMATION (COMPLETE AS APPLICABLE TO YOUR AGENCY'S ROLE)		
Incident Date:	Incident Name:	
Incident Location:		
Dispatch Time:	On Scene Time:	Incident End Time:
First Responder Agencies Utilized:		
Ground Transport Agencies Utilized:		
Air Transport Agencies Utilized:		
Other Type Of Transport Resources Utilized:		
Incident Commander:	Medical Group Supervisor:	
Triage Unit Leader:	Treatment Unit Leader:	
Pt. Trans. Unit Leader:	Were MCI ID Vests Used? ☐ Yes ☐ No	
Were Triage Tags Used? ☐ Yes ☐ No	Were Pt. Tracking Sheets Used? ☐ Yes ☐ No	

Number And Type Of Patients			
IMMEDIATE:	DELAYED:	MINOR:	DECEASED:
Total # Of Adult Patients:		Total # Of Pediatric Patients:	
# Of Patients Transported:		# Of Patients Refusing Transport:	

Hospital Information (Note: CF = Control Facility)	
CF Name:	Initial CF Contact Time:
Initial CF Notification Received From (Dispatch, Field, etc.):	
Number Of CF Staff Assigned:	CF Pt. Dispersal Officer:
Receiving Facilities Utilized:	

MCI COMMENTS/ISSUES/SUGGESTIONS/OBSERVATIONS