MCI FEEDBACK/REPORTING FORM

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:	First Unit On Scene Time:
First Transport Unit On Scene Time:	Supervisor On Scene Time:
Last Pt Extrication Completion Time:	Incident End Time:

NUMBER & TYPE OF PREHOSPITAL EMS RESOURCES			
First Responder Agencies Utilized:			
Ground Amb. Providers Utilized:			
# of Ground Amb. Requested:		# of Ground Amb. Utilized:	
HEMS Providers Utilized:			
# of HEMS Aircraft Requested:		# of HEMS Aircraft Utilized:	
Other Transport Resources:			
Incident Commander:		Transportation Unit Leader:	
Triage Unit Leader:		Med. Communications Coord.:	
Treatment Unit Leader:		Were MCI ID Vests Used? ☐ Yes ☐ No	
Were Triage Tags Used? ☐ Yes ☐ No		Were Pt. Tracking Sheets Used? ☐ Yes ☐ No	

NUMBER & TYPE OF PATIENTS			
IMMEDIATE:	DELAYED:	MINOR:	DECEASED:
# Of Adult Pts:		# Of Pediatric Pts:	
# Of Pts Transported by EMS:		# Of Pts Refusing Transport:	

HOSPITAL INFORMATION (CF = CONTROL FACILITY)	
CF Name:	Initial CF Contact Time:
Initial CF Notification Received From:	
Number Of CF Staff Assigned:	CF Pt Dispersal Officer:
Receiving Facilities Utilized:	

MCI COMMENTS/ISSUES/SUGGESTIONS/OBSERVATIONS (REQUIRED)