Please note: as per the Region 1 Emergency Incident Rehabilitation Policy symptomatic department members will be transported to the hospital.

Emergency Incident Rehabilitation Report

Times	Name/Agency	Temp	Resp	Pulse	B/P	SpO2	SpCO	Treatment Provided (if any)	Discharged To:	
In										Member
										signature: ___________________________
Out										
Times	Name/Agency	Temp	Resp	Pulse	B/P	SpO2	SpCO	Treatment Provided (if any)	Discharged To:	
In										Member
										signature: ___________________________
Out										
Times	Name/Agency	Temp	Resp	Pulse	B/P	SpO2	SpCO	Treatment Provided (if any)	Discharged To:	
In										Member
										signature: ___________________________
Out										
Times	Name/Agency	Temp	Resp	Pulse	B/P	SpO2	SpCO	Treatment Provided (if any)	Discharged To:	
In										Member
										signature: ___________________________
Out										
Times	Name/Agency	Temp	Resp	Pulse	B/P	SpO2	SpCO	Treatment Provided (if any)	Discharged To:	
In										Member
										signature: ___________________________
Out										
Times	Name/Agency	Temp	Resp	Pulse	B/P	SpO2	SpCO	Treatment Provided (if any)	Discharged To:	
In										Member
										signature: ___________________________
Out										
Times	Name/Agency	Temp	Resp	Pulse	B/P	SpO2	SpCO	Treatment Provided (if any)	Discharged To:	
In										Member
										signature: ___________________________
Out										

Incident: ____

Location: ____

Date: ____

Printed name of care provider(s) ____

Incident Commander: ____________________________________

EMS Coordinator Signature: ____

Date received: ____