UB|MD EMERGENCY MEDICINE EMS DIVISION

Monthly Prehospital Care Report (PCR) Submission Form

For month of ___________, 20____

Agency Name: ____ **Agency code** ___ ___ ___ ___

Agency Type: ALS First Responder ALS Transporting BLS Transporting

Name of individual filing report: ________________________________ **Phone:** (_____)______-_______

Number of *COMPLETED* PCRs submitted: _______________

Number of *VOID* PCRs submitted: (+) _______________

Total number of PCRs Submitted: (=) _______________

I attest that the PCRs submitted by the agency above have been counted and screened for the items below and that all PCRs are complete. Check items below to indicate completion of screening for all PCRs:

- ☐ Date of Incident
- ☐ Agency Code
- ☐ Location Code
- ☐ Presenting Problem
- ☐ Patient name
- ☐ Deposition code
- ☐ Patient Date of Birth

Please make the appropriate adjustments to PCRs prior to submission.

Completed PCRs need to be submitted monthly to the UBMDEMS Division by the 10th of the month following the call.

The Office of Prehospital Care will not accept:

- **Photocopies of PCRs**
- **Hospital ('pink') or Agency ('white') copies of PCRs**
- **Rhythm strips**
- **Any other form specific to your Agency**

Please send PCRs along with this cover page to:

UBMD EMS Division
462 Grider Street
Buffalo, NY 14215
ATTN: PCR Specialist

______*(Signature of individual filing report)*______ ______*(Date)*______