



Commonwealth of Massachusetts
 Executive Office of Health and Human Services
 Department of Public Health
 Bureau of Health Care Safety and Quality
OFFICE OF EMERGENCY MEDICAL SERVICES

**EMERGENCY MEDICAL SERVICES (EMS)
 SERIOUS INCIDENT REPORT FORM**

**For self-reporting of incidents to the Massachusetts Department of Public Health's Office of
 Emergency Medical Services (DPH/OEMS) by licensed ambulance services and accredited EMS
 training institutions (ATIs) only**

Ambulance services and accredited EMS training institutions are required to immediately notify the Department by electronic mail or telephone and file a written report with the Department within seven calendar days of serious incidents involving its service, personnel, or property.

(1A.) Name of Reporting Ambulance or EFR Service: _____

(1B.) Name of Reporting ATI: _____

(2.) Name/Title of Person Completing Form: _____

• Phone: _____

• Email: _____

(3.) Date of Incident: _____

(4.) Names and MA certification numbers of EMS personnel; names of EMS students involved:

(5A.) Patient Care Report(s)/Number(s): _____

Copy Attached _____

Copy Not Attached (Please explain why):

(5B.) If ATI, Course Registration Number: _____

Course Level: _____

Incident occurred during which phase of course:

a. Didactic (classroom)

b. Laboratory (classroom)

c. Clinical Internship (hospital)

1. Hospital Involved: _____

d. Field Internship (EMS)

1. Ambulance Service Involved: _____

2. Will that ambulance service be submitting a separate serious incident report? _____

(6.) Nature of Incident (check all that apply):

- a. PATIENT INJURY RESULTING FROM THE INCIDENT (including if MVC)
- b. MEDICATION ERROR (whether or not patient injury occurred)
- c. EMS REGULATIONS OR PROTOCOL VIOLATION
- d. MEDICAL/COMMUNICATION DEVICE FAILURE
- e. REPORTABLE MOTOR VEHICLE CRASH (Submit RMV Motor Vehicle Crash Operator or Police Report)
 - i. VEHICLE LICENSE PLATE # _____
 - ii. IN WHAT TOWN DID MVC OCCUR? _____
 - iii. AMBULANCE USING LIGHTS AND SIRENS AT THE TIME? _____
 - iv. PATIENT ON BOARD AT THE TIME? _____
 - v. WHAT POINT IN SHIFT WAS EMS PERSONNEL DRIVING (i.e., how long had they been on shift when MVC occurred)? _____
- f. VEHICLE FIRE*
 - i. VEHICLE LICENSE PLATE # _____
 - ii. IN WHAT TOWN DID FIRE OCCUR? _____
- g. VEHICLE THEFT*
 - iii. VEHICLE LICENSE PLATE # _____
 - iv. FROM WHAT TOWN WAS VEHICLE STOLEN? _____
- h. OTHER (EXPLAIN) _____

(7.) Brief description of incident:

NOTE: The service or ATI shall submit an investigation report and Plan of Correction and Preventability, with documentation that the service or ATI's affiliate hospital medical director has reviewed, had input into and agrees with the Plan, **within 30 days**, by email to oems.sir@state.ma.us or fax to: (617) 753-7320.

SIGNATURE and TITLE

DATE SIGNED

PRINT NAME

EMT NUMBER (if any)

NOTE: NOTIFY DPH/OEMS IMMEDIATELY BY PHONE, 617-753-7300, OR BY EMAIL AT OEMS.SIR@state.ma.us, and SUBMIT SERIOUS INCIDENT REPORT. FORM MUST BE SUBMITTED WITHIN 7 CALENDAR DAYS FOLLOWING INCIDENT INVOLVING ITS PROGRAM, PERSONNEL OR PROPERTY.