Monthly Prehospital Care Report (PCR) Submission Form

For month of _____, 20____

Agency Name: _____ **Agency code** ___ ___ ___ ___

Agency Type (circle)**:** ALS First Response ALS Transport BLS Transport BLS First Response

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
- ☐ Patient Social Security Number
- ☐ Patient Date of Birth

Please make the appropriate adjustments to PCRs prior to submission.

Completed PCRs need to be submitted monthly to the Office of Prehospital Care 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:

Office of Prehospital Care
462 Grider Street
Buffalo, NY 14215
ATTN: PCR Specialist

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