DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-00703 (01/2013)

STATE OF WISCONSIN
Bureau of Communicable Diseases and Emergency Response
ss. 256.15, Wis. Stats.
(608) 266-1568

PATIENT SIDE TRAINING REPORT

Completion of this form designates that an ambulance service transported a medication that does not appear on the "Wisconsin Paramedic Curriculum Based Medication List" or the services approved operational plan. This medication was transported by the ambulance service using *Patient Side Training Report* provided by the transferring facility. Additional transports using this medication will require the following to be submitted and approved by the Wisconsin Emergency Medical Services (EMS) Office before additional transports can occur with this medication: 1) Protocol for the medication, 2) Medical Director approval in writing, 3) Training plan for the medication

SERVICE INFORMATION

Service Name	**State Provider Number**		
Service Director Name	**Medical Director Name**		
Mailing Address	**City**	**State**	**Zip Code**
Name and License Number of EMS Personnel No.1	**Name and License Number of EMS Personnel No. 2**		
Daytime Telephone Number	**Other Telephone Number**	**E-Mail Address of Submitter**	

MEDICATION INFORMATION

Medication Name	**Patient Care Report Number**
Dosage of Medication	**Method of Administration (IV Pump, Gravity, IV Push, etc.)**
Other Medications Also Administered ☐ YES ☐ NO	**If Yes, Please Identify the Other Medications**
Sending Facility Name / Location of the Patient	**Name and Credential of Person Providing the Training**

SERVICE CERTIFICATION

I have received notice that the medication listed above has been transferred in accordance with the *Patient Side Training Report*. I also realize this medication is not on the "Wisconsin Paramedic Curriculum Based Medication List" or in our approved service operational plan. I certify that before this medication is transferred again by my service, I will submit and have approved 1) Protocol for the medication, 2) Medical Director approval in writing, and 3) Training plan for the medication. I also understand that additional transports utilizing this medication are against scope of practice and may result in disciplinary actions against my service up to and possibly including revocation of my service license.

Signature - Service Director _____ Date Signed _____

MEDICAL DIRECTOR CERTIFICATION

I have been notified of a medication that is not approved for the service, for which I am the medical director, has been transported in accordance with the *Patient Side Training Report*. I further certify that before this medication is transported by my service, I will submit and have approved 1) Protocol for the medication, 2) Medical Director approval in writing, and 3) Training plan for the medication. I also understand that additional transports utilizing this medication are against scope of practice and may result in disciplinary actions against my service up to and possibly including revocation of my service license

SIGNATURE - Medical Director _____ Date Signed _____

SCAN and EMAIL completed form to the State PARAMEDIC COORDINATOR

Clear / Reset Form