MEDICAL PERSONNEL CHECK-IN

ROCKY MOUNTAIN INCIDENT MANAGEMENT

PERSONAL INFORMATION

NAME: ______________________________ PHONE NUMBER: ______________

EMAIL: ______________________________ FIRST WORKDAY: ______________

DATE: __________ RESOURCE #: __________ POSITION: ______________

WERE YOU REASSIGNED FROM ANOTHER INCIDENT: Y / N INCIDENT NAME: ______________

ABILITY TO EXTEND: Y / N WOULD YOU REASSIGN: Y / N AGE: ______________

AGENCY INFORMATION

AGENCY: ______________________________ AGENCY ID: ______________

AGENCY CONTACT: ______________________ PHONE NUMBER: ______________

AGENCY CONTACT EMAIL: ____

AGENCY ADDRESS: ____

POSITION AT AGENCY: ______________________ TIME IN POSITION: ______________

YEARS OF WILDLAND FIRE EXPERIENCE: _______ NUMBER OF WILDLAND FIRES: _______

CERTIFICATION INFORMATION

CERTIFICATION LEVEL: __________ STATE: _____ CERTIFICATION #: _______ EXP: _______

NR CERTIFICATION LEVEL: __________ CERTIFICATION #: _______ EXP: _______

CPR EXP: _______ ACLS EXP: _______ ADDITIONAL CERTIFICATIONS: ______________

MEDICAL DIRECTOR: ______________________ PHONE NUMBER: ______________

EQUIPMENT

EQUIPMENT	X	DESCRIPTION
ALS KIT		
BLS KIT		
AED		
CARDIAC MONITOR		
MEDICATIONS		
ACLS MEDICATIONS		
NARCOTICS		
OTC SUPPLIES		
IV SUPPLIES		
ADVANCED AIRWAY		
SPLINTING		
BACKBOARD		
SKED		
VEHICLE		