

FACT SHEET ABOUT REQUESTS FOR FIRE OR PENNA. EMERGENCY MEDICAL SERVICES REPORT

PLEASE RETAIN TOP PORTION OF FORM FOR YOUR FILES. NOTE THE DATE YOU MAILED YOUR REQUEST AND CONTROL NUMBER AND ANY INFORMATION THAT MAY BE PERTINENT TO YOU. WHEN APPLYING FOR AN EMERGENCY MEDICAL SERVICES REPORT IT IS ESSENTIAL TO COMPLETE THE "AUTHORIZATION FOR RELEASE" STATEMENT ON THE OPPOSITE SIDE.

CONTROL NUMBER

NAME AND/OR FILE NUMBER

DATE MAILED

Your application will be forwarded to the Philadelphia Fire Department who will prepare and mail directly to you a copy of the report. Please be specific on the application about the name and correct address to whom you want the report mailed. If the address is in a building, please give room number.

It is essential that the information provided on this application is accurate. Insufficient, incorrect or vague information may impede the search. Report number/Billing number must be given in order to obtain a report of a fire and/or Emergency Medical Services report. REFUNDS WILL NOT BE MADE.

Please allow 6—8 weeks after you mail your application to the Department of Records to receive your report by mail. When inquiring about the status of your report, you must provide the Department of Records with the application number located in the upper right hand corner of your receipt. (pink half sheet)

APPLICATIONS BY MAIL OR IN PERSON

Department of Records
Room 167 • City Hall
Philadelphia, PA 19107
(215) 686-2266
8:00 AM — 2:00 PM (Monday — Friday)

INQUIRIES CONCERNING REPORTS

Philadelphia Fire Department
240 Spring Garden Street
Philadelphia, PA 19123
(215) 686-1313 — FOR EMS REPORTS
(215) 686-1366 — FOR FIRE REPORTS

**PLEASE MAKE CHECK/MONEY ORDER PAYABLE TO: "CITY OF PHILADELPHIA"
TO EXPEDITE SERVICE PLEASE SEND A SELF-ADDRESSED, STAMPED ENVELOPE.
FEE — NOT REFUNDABLE
THANK YOU FOR APPLYING BY MAIL**

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| APPLICATION FOR FIRE AND/OR PENNSYLVANIA EMERGENCY MEDICAL SERVICES PLEASE DO NOT FILL OUT AN APPLICATION IF YOU ARE NOT CERTAIN OF YOUR DATA. INSUFFICIENT, WRONG OR VAGUE INFORMATION MAY RESULT IN A NEGATIVE REPORT. | | CITY OF PHILADELPHIA DEPARTMENT OF RECORDS <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px auto;"></div> — PLEASE PRINT — |
| PARTY REQUESTING REPORT (NAME OF APPLICANT) | | APPLICATION DATE |
| REPORT TO BE MAILED TO (COMPLETE ADDRESS INCLUDING NAME, COMPANY, STREET ADDRESS AND ZIP CODE) | | TELEPHONE NUMBER OF APPLICANT |
| | | FILE CLAIM NUMBER |
| COMPLETE THIS BLOCK FOR FIRE REPORT: | | REPORT NUMBER: |
| DATE OF FIRE | TIME | ADDRESS OF FIRE |
| | | |
| COMPLETE THIS BLOCK FOR MEDIC UNIT REPORT: | | REPORT NUMBER/ BILLING NUMBER: |
| DATE OF SERVICE | TIME | NAME OF INJURED PARTY |
| | | |
| LOCATION OF INCIDENT (EXACT STREET LOCATION WHERE INCIDENT OCCURRED) | | |
| FEE \$20. — NOT REFUNDABLE (\$1.00 each additional page) | | The "AUTHORIZATION FOR RELEASE" on the reverse side must be completed for all requests for Penna. Emergency Medical Services Reports. |
| IF YOU HAVE A DISABILITY AND REQUIRE AN ACCOMMODATION IN ORDER TO COMPLETE THIS FORM AND/OR TO PARTICIPATE IN A PROGRAM OR SERVICE, CONTACT THE ADA COORDINATOR AT 686-2266. | |  |
| 82-311A (Rev. 6/04) | | |

AUTHORIZATION FOR RELEASE OF PENNSYLVANIA EMERGENCY MEDICAL SERVICES REPORT

Includes the Pennsylvania Emergency Medical Services Report, any addended narratives and EKG Documentation Sheet.

By my Signature below, the City of Philadelphia is hereby authorized to release Pennsylvania Emergency Medical Services Reports to:

| INFORMATION | | RELEASED TO | |
|--|---------------------------|---------------|--|
| NAME | ADDRESS | | |
| PATIENT | | INFORMATION | |
| PATIENT'S NAME | AGE | DATE OF BIRTH | |
| ADDRESS | | | |
| PENNSYLVANIA EMERGENCY MEDICAL SERVICES INFORMATION | | | |
| <i>(Please supply as much information as is available, it will help the Department of Records to fulfill your request)</i> | | | |
| RECEIVING HOSPITAL | DATE OF SERVICE | TIME | <input type="checkbox"/> AM <input type="checkbox"/> PM |
| ADDRESS | PA. EMERG. MED. SERV. NO. | | |
| * PATIENT'S SIGNATURE OR REASON WHY PATIENT IS UNABLE TO SIGN | | DATE | |
| *RECORDS MAY NOT BE RELEASED WITHOUT SIGNATURE OF PATIENT. <i>If a patient is unable to sign († minor, decease, physically or mentally incapacitated), a legally qualified representative (parent, next of kin, legal guardian, spouse, administrator, executor of estate) may sign in lieu of patient.</i> | | | |
| † SIGNATURE OF LEGALLY QUALIFIED REPRESENTATIVE (READ STATEMENT ABOVE) | | DATE | |
| REPRESENTATIVE'S NAME (PRINT) | RELATIONSHIP TO PATIENT | | |