F&EMSD Form 502
Rev. 11/07

District of Columbia Fire and EMS Department

EMS Evaluation Report

Name: _____ FDID: _____ Incident#: _____

Date: _____ Paramedic: ☐ EMT-I: ☐ EMT: ☐ Assignment/Unit: _____

INSTRUCTIONS:

1. Is the candidate's performance medically and operationally appropriate, adequate and compliant with department standards? Check ***Yes*** or ***No.***

2. For each ***Yes*** or ***No*** checked, provide supporting written documentation of observations, pertinent negatives, and methods of compliance.

3. Completed form will have each line-item checked ***Yes*** or ***No*** with appropriate remarks.

STANDARDS:

PROFESSIONALISM-Vehicle and equipment clean and well repaired. Uniform complete, clean, and orderly; including rank insignia, name plate and PAT tag. Language without oaths, vulgarity, colloquialism. Clearly understood by patient, bystanders and team. All necessary signatures obtained and appropriate patient hand off in event of care transfer.

COMPASSION-Recognized and attended to patient's complaint, concern and needs. Avoided argumentative or judgmental language or behavior. Demonstrated caring behavior. Attended to patient comfort. Recognized and eased anxiety, fear, and concern. Recognized and supported family, bystanders as necessary.

PSYCHOMOTOR SKILLS-Performed appropriate skills. Performed according to the standard of care. Performance adhered to protocol. Complete including necessary evaluations prior to and after skills are performed. Understood and demonstrated problem solving to complete skill. Aseptic technique where required, clean technique otherwise. Appropriate use of personal protective gear (gloves, masks, etc.).

DECISION MAKING-Selected correct algorithm for chief complaint, assessment, and history.
Selected correct destination, include transport to appropriate specialty centers for trauma, pediatrics, cardiac, stroke, burn and non-critical emergencies. Appropriate interventions utilized. Hospital pre-notification and/or on-line medical control performed, if appropriate.

TREATMENT-Assessment complete, appropriate for patient. Interventions appropriate and complete. Scene time meets department standards-critical trauma-10minutes or less, all others 15 minutes or less. 902, ePCR, complete. Necessary documentation delivered to hospital. Medications administered per protocol. EKG interpretation accurate. Patient changes noted. Ongoing assessment conducted every 5 minutes for critical patient, every 15 minutes for non-critical. Documentation of all assessments. Appropriate physical exam completed for all non-critical patients. Rapid trauma assessment completed for all critical trauma patients. Assessment and treatment appropriate for mechanism of injury.

Distribution: Original - Medical Director
Copy - Batt. File
Copy - Co. File

District of Columbia Fire and EMS Department

EMS Evaluation Report

	YES	NO	Performance Remarks
PROFESSIONALISM			
Apparatus			
Uniform/Attire Complete			
Teamwork Effective			
Appropriate Patient Interaction			
Work Ethic			
COMPASSION	YES	NO	
Ensured Patient Comfort			
Empathy for Patient Concern			
PSYCHOMOTOR SKILLS	YES	NO	
Chose Correct Procedures			
Performed Skill Completely			
Performed Correctly			
Post Skill Evaluation Appropriate			
DECISION MAKING	YES	NO	
Correct Triage			
Appropriate Destination			
Interventions			
Scene - Time Appropriate			
TREATMENT	YES	NO	
Appropriate Algorithm			
Efficient			
Complete			
Medications			
Skills			
Assessment			
Documentation			

Notes: _____

_____

_____

_____	_____	_____
Printed Name of EMS Official	Signature of EMS Official	Date
	_____	_____
	Provider's Signature	Date

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Rev. 11/05

Provider Clinical Impression

Provider Name: _____ **EMT-B** ____ **EMT-A** _____ **EMT-I** _____ **EMT-P** _____

Supervisor: _____ **Years of Service at the Above Level:** _____

Date: _____ **Number of Incidents on Which Provider was Observed:** _____

Incident No. _____, _____, _____, _____, _____,

_____, _____, _____, _____, _____

All Provider Skills

Please rate the provider on the following skills and attributes utilizing the following scale. Place a check mark in the corresponding column for your impression of that skill or attribute.

Exceptional = 4 Acceptable & Consistent = 3 Inconsistent = 2* Frequently Unsuccessful = 1*

**Note: All ratings of 1 or 2 must be explained fully in the comments section.*

Skill/Attribute	4	3	2	1	Not Applicable
Patient Assessment					
General Protocol Knowledge					
Respiratory Knowledge/Skills					
Pharmacology Knowledge					
Trauma Knowledge/Skills					
Combitube/Airway Management					
Intravenous Access					
Charting Skills					
Utilizes Available Resources Efficiently					
Provider Follows Direction					
Provider Performs Well in a Leadership Role					

Provider Can Function Effectively on "1+1" Unit? _____ Yes _____ No *(If "NO"Explain Below)*
a

EMT-1 or EMT-P Skills

Please rate the Intermediate or Paramedic on the following additional skills and attributes utilizing the same scale as above. Place a check mark in the corresponding column for your impression of that skill or attribute.

4

Skill/Attribute	4	3	2	1	Not Applicable
ACLS Knowledge					
Intubation /Airway Management					
ECG / Rhythm Interpretation					

Additional comments (Use back if needed): _____

_____

Provider Signature* _____ Supervisor Signature _____

** Signature does not indicate agreement with the report, but an acknowledgement of viewing the report*

Distribution: Copy to EMS Operations Chief (all members), Copy to Co. Officer (members assigned to FFD), Copy to Member

Provider Clinical Impression

Additional Comments (continued):

District of Columbia Fire and EMS Department

Clinical Incident Report Form

FEMSD
Form 504
06/07

Incident Specifics:

Date	/ /	Time	: AM PM	Incident Number	

Assigned Units	

Reporting Officer	

Patient Name	

Priorities:

Dispatch Priority		Transport Priority	

Times:

Dispatch		On-Scene		Hospital Arrival	

Providers:

Primary Provider		Assignment	
Secondary Provider		Assignment	
Secondary Provider		Assignment	
Secondary Provider		Assignment	
Secondary Provider		Assignment	

Witnesses:

Witness Name		Contact Number	
Witness Name		Contact Number	

Receiving Facility:

Receiving Facility	
Receiving Nurse	
Receiving Physician	

Clinical Issue Category (Choose All That Apply):

	Professionalism		Cultural Sensitivity		Compassion
	Clinical Competence		Clinical Judgment		Other

Supporting Factors (Use Back for Additional Information):

Quality Mgmt Officer's Signature		Date	
Forwarded To		Date	

District of Columbia Fire and EMS Department

Clinical Incident Findings Form

FEMSD Form
505
04/07

Incident Specifics:

Date	/ /	Time	: AM PM	Incident Number	

Assigned Units	

Reporting Officer	

Patient Name	

Priorities:

Dispatch Priority		Transport Priority	

Times:

Dispatch		On-Scene		Hospital Arrival	

Providers:

Primary Provider		Assignment	
Secondary Provider		Assignment	
Secondary Provider		Assignment	
Secondary Provider		Assignment	
Secondary Provider		Assignment	

Witnesses:

Witness Name		Contact Number	
Witness Name		Contact Number	

Receiving Facility:

Receiving Facility	
Receiving Nurse	
Receiving Physician	

Clinical Issue Category (Choose All That Apply):

	Professionalism		Cultural Sensitivity		Compassion
	Clinical Competence		Clinical Judgment		Other

Supporting Documents Attached (Choose All That Apply):

	Form 502 / Form 503 / Form 504		Statement from Patient
	Patient Care Report		Statement from Family
	Form 902 EMS		Statement from Witness(es)
	CAD Report		Statement from Nurse(s)
	Special Reports		Statement from Physician(s)
	Statement from Provider(s)		

Quality Mgmt Officer's Signature		Date	
Forwarded To		Date	