CENTRAL NEW YORK REGIONAL EMERGENCY MEDICAL SERVICES COUNCIL, INC.

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SYRACUSE, NEW YORK 13202
WWW.CNYEMS.ORG

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(800) 295-2195
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SUBMISSION FORM

(Enclose with the monthly PCR submission for the agency stated below)

AGENCY NAME: _____

AGENCY CODE: _____

AGENCY CERTIFICATION: ☐ BLS/ALS Transport ☐ ALS NonTransport ☐ BLS NonTransport

SUBMISSION STATISTICS:

_____ _____
Month Number of PCRs

_____ _____
Month Number of PCRs

PROPER SCREENING:

I, (**Agency Designee**) _____ 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 Geo-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**.*
** All PCRs are to be sent to CNYEMS by the 12th day of the month for PCRs of the previous month.*
** CNYEMS will not accept the following:*

Photocopies of PCR's (under any circumstance)
Hospital (PINK) or Agency (WHITE) copies of PCR's
Continuation Forms
Rhythm Strips
Any other Agency specific form

_____

Signature of Agency Designee