PROTOCOL DEVIATION FORM

Agency Name: ____________________________

Incident Number: ________________ Type of Deviation:  
Date: ____________________________  ☐ Procedure  
Time: ____________________________  ☐ Medication  
Other: ____________________________

HOSPITAL/PHYSICIAN INFORMATION

Where was the patient transported? ____________________________

Was the Physician contacted prior to the protocol deviation? ☐ Yes ☐ No  
Physician Name: ____________________________

CREW INFORMATION

Name: ____________________________
SNHD EMS Number: _________
Certification Level: _________

Name: ____________________________
SNHD EMS Number: _________
Certification Level: _________

What is the specific deviation? (Do not describe why, simply state what it was.)

________________________________________________________________________

Why did this occur?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Attach a separate sheet of paper if more space is needed.