



CENTRAL DUPAGE HOSPITAL EMERGENCY MEDICAL SERVICES SYSTEM

25 NORTH WINFIELD ROAD
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NON-DISPOSABLE EQUIPMENT RECEIPT

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY.

ONE COPY IS TO BE RETAINED BY AGENCY LEAVING EQUIPMENT, SECOND COPY TO BE LEFT WITH RECEIVING FACILITY EMS OFFICE.

PURSUANT TO THIS FORM, NAMED HOSPITAL AGREES TO ACCEPT RESPONSIBILITY FOR THE SAFEKEEPING OF THE FOLLOWING EQUIPMENT:

EQUIPMENT NAME OR DESCRIPTION:

QUANTITY:

EQUIPMENT NAME OR DESCRIPTION:	QUANTITY:
_____	_____
_____	_____
_____	_____
_____	_____

FACILITY NAME: _____

DATE EQUIPMENT LEFT: ____ / ____ / ____

TIME: _____ HRS

EMS REPORT #: _____

EMS AGENCY NAME: _____ UNIT / VEHICLE #: _____

SIGNATURE OF EMS PROVIDER: _____

PRINTED NAME OF EMS PROVIDER: _____

SIGNATURE OF INDIVIDUAL RECEIVING EQUIPMENT: _____

PRINTED NAME OF INDIVIDUAL RECEIVING EQUIPMENT: _____

IF EQUIPMENT IS NOT LABELED WITH EMS AGENCY NAME, DO NOT SIGN

DATE EQUIPMENT RETURNED: ____ / ____ / ____

SIGNATURE OF EMS PROVIDER RECEIVING EQUIPMENT: _____

PRINTED NAME OF EMS PROVIDER RECEIVING EQUIPMENT: _____

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