



OREGON HEALTH AUTHORITY
EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEMS

PREHOSPITAL CARE REPORT ORDER FORM

50310 50305 2525
QC-510

Agency Name: _____

Physical Address: _____

Contact Name: _____

Contact Phone: _____

IMPORTANT NOTICE

This order form must be returned to Oregon Health Authority – EMS. Orders must be accompanied by a check or money order. The full order will be sent to the address above.

_____ Pre-printed Standard Report Forms @ \$.18/Form \$ _____
(Cost of Shipping & Handling Included)

Please make your check payable to the Oregon Health Authority -EMS

Mail to:

Oregon Health Authority -EMS
PO Box 14450
Portland, OR 97293-0260