



OREGON HEALTH AUTHORITY  
EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEMS

PREHOSPITAL CARE REPORT ORDER FORM

50202 51274 2715

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 and Handling Included)

TOTAL ORDER AMOUNT \$ \_\_\_\_\_

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