F-66: 02 - 02

THE CITY OF WINNIPEG – FIRE PARAMEDIC SERVICE

DAILY TIME RECORD FOR ACTING PAY PURPOSES FOR MONTH ENDING .... 20........

Station No. .... Platoon No. .... Reg. No. .... Rank .... Name ....

ON DUTY		OFF DUTY		SUBSTITUTING IN HIGHER RANK FOR:				REASON	CERTIFIED CORRECT (CHIEF OFFICER/INSPECTOR)	Office Use Only
DATE	TIME	DATE	TIME	STN	PLA-TOON	RANK	NAME			PAYABLE HOURS
								TOTALS		

FORWARDED ....
Chief / Inspector / Captain

Paid .... Hours@ .... per Hour Diff. in Rate - $ .... on Payroll for Pay Period No. .... Ending ....
CERTIFIED

CW691: 02 02

F-66: 02 - 02

THE CITY OF WINNIPEG – FIRE PARAMEDIC SERVICE

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Station No. .... Platoon No. .... Reg. No. .... Rank .... Name ....

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									TOTALS	

FORWARDED ....
Chief / Inspector / Captain

Paid .... Hours@ .... per Hour Diff. in Rate - $ .... on Payroll for Pay Period No. .... Ending ....

....
CERTIFIED

CW691: 02 02

DRIVER TO COMPLETE PROMPTLY, AND FORWARD IMMEDIATELY TO EMSB.

The City of Winnipeg Fire Paramedic Service
Collision Report (Please Print)

Work Order #: office use only | **MPI Claim #:** office use only | **WPS Incident #:**

WFPS Incident # (EMS): | **WFPS Incident # (FIRE):**

WFPS Vehicle #: | **Make:** | **Year:** | **Unit #:**

License Plate #: | **Prov. Fleet Unit #:** | **Serial #:**

Hour Meter: | **KMs / Miles:** | **Date of collision:** | **Time:**

Direction of Travel: ❑ North ❑ South ❑ East ❑ West | **"Address" of collision:**

Proximity to station at time of collision: within ❑1 block ❑ 2 blocks ❑ 3 blocks ❑ 4 blocks ❑ 5 blocks ❑ greater than 5 blocks ❑ parking lot ❑ other (please provide explanation in narrative)

Departure location: | **Location dept. vehicle last stopped:**

Were you responding to an alarm?: ❑ yes ❑ no | **Incident Code:** 1 2 3 4 | Police in Attendance: ❑ yes ❑ no

Collision occurred:
❑ on way to scene (❑ street or ❑ intersection) ❑ at scene ❑ on way to station/hospital from scene (❑ street or ❑ intersection) ❑ at Academy ❑ at event (i.e. parade) ❑ Station ❑ other (please provide explanation in narrative)

Luminosity: ❑ dark ❑ daylight ❑ dawn ❑ dusk ❑ cloudy day ❑ cloudy night

Visibility: ❑ excellent ❑ good ❑ poor ❑ terrible State distance of visibility if below poor: _____ meters

Precipitation: ❑ snow ❑ rain ❑ freezing rain ❑ frost ❑ sleet ❑ hail ❑ fog ❑ none

Intensity of precip.: ❑ light ❑ moderate ❑ heavy ❑ n/a | Streetlights: ❑ on ❑ off

Windows: ❑ clear ❑ wet ❑ steamed ❑ frosted ❑ snow adhering

Road Conditions: ❑ snow ❑ icy ❑ wet ❑ dry ❑ frosty ❑ muddy ❑ level ❑ upgrade ❑ downgrade ❑ under construction

Traffic signals @ collision intersection: ❑ yes ❑ no If "yes" was it: ❑ fixed ❑ flashing | **What color signal did you have?:** ❑ red ❑ amber ❑ green

Did WFPS vehicle have a stop sign?: ❑ yes ❑ no If "yes", did you stop: ❑ yes ❑ no | **Did other vehicle have a stop sign?:** ❑ yes ❑ no If "yes", did driver stop: ❑ yes ❑ no

Indicate visual / audible warning system(s) in use: ❑ Headlights ❑ Running lights ❑ Turn Signal ❑ Brake lights ❑ Siren ❑ Horn ❑ Air Horn ❑ Emergency Warning Lights ❑ Beacons ❑ 4-way ❑ Windshield Wipers ❑ Retarder / Governor ❑ ABS ❑ Other: ______________________________

Was there anything to obstruct your view?: ❑ no ❑ yes, (describe) ______________________________________

Was there anything to obstruct the view of the other driver?: ❑ yes ❑ no

Where was the other vehicle when you first saw it?:

Name of person you notified of collision: | **Photos taken?** ❑ yes ❑ no

# of dept. members involved in collision: | **# of civilians involved in collision:**

Other Driver / Vehicle Information

Driver's Name: | Driver's Address: | Prov.:

License plate #: | Prov: | Model/Make: | Year:

Driver Gender: ❑ male ❑ female | Age: | Driver's license #: | Expiry Date:

Home phone #: | Work phone #: | Cell #:

Owner's Name: | Owner's Address: | Prov.:

Phone #: | Work phone #: | Cell phone #:

Seat belts were worn: ❑ yes ❑ no ❑ unknown | Insured By: | Policy #:

Veh. Damage: ❑ destroyed ❑ substantial ❑ minor ❑ none | Total occupants in vehicle:

Driver Comments:

WFPS Driver / Vehicle Information

Name: | Reg. #: | Stn./Pltn.: | Branch:

Gender: ❑ male ❑ female | Age: | Driver's license #: | Expiry Date:

Class: 1 2 3 4 5 6 | Restrictions: 1 2 3 4 5 6 7 8 9 | Prescrip. eyewear worn: ❑ yes ❑ no

Home address: | Home ph. #: | Veh. Damage: ❑destroyed ❑substantial ❑minor ❑ none

Seat Belts: used by driver: ❑ yes ❑ no ❑ n/a used by passenger #1: ❑ yes ❑ no ❑ n/a
used by passenger #2: ❑ yes ❑ no ❑ n/a used by passenger #3: ❑ yes ❑ no ❑ n/a

Whom do you feel is responsible for the collision?: ❑ WFPS driver / crew ❑ civilian driver ❑ other (explain in narrative)

Independent Witness Information (#1) (attach additional sheets if required)

Name: | Address:

Gender: ❑ male ❑ female | Age: | Location as witnessed accident:

Home phone #: | Work phone#: | Cell #:

Whom do you feel is responsible for the collision?: ❑ WFPS Crew ❑ civilian vehicle ❑ other (explain in narrative)

Witness Comments:

Injury Information (attach additional sheets if required)

Name	Address	Crew / Civ.	Position	Degree of Injury	Age	Phone #:
		❑ Crew ❑ Civ.	❑ driver ❑ passenger ❑ bystander ❑ patient	❑ minor ❑ serious ❑ fatal		
		❑ Crew ❑ Civ.	❑ driver ❑ passenger ❑ bystander ❑ patient	❑ minor ❑ serious ❑ fatal		
		❑ Crew ❑ Civ.	❑ driver ❑ passenger ❑ bystander ❑ patient	❑ minor ❑ serious ❑ fatal		

DRIVER TO COMPLETE PROMPTLY, AND FORWARD IMMEDIATELY TO EMSB.

Narrative Description of Collision (diagrams must be used)

Reminder: This is a legal document.

Indicate North

Show by "x" markings points of contact on vehicles involved in collision.

Officer Name (Print) | Officer Signature | Reg. # | Stn. #

Driver Name (Print) | Driver Signature | Reg. # | Stn. #

CW1018:2004 07

DRIVER TO COMPLETE PROMPTLY, AND FORWARD IMMEDIATELY TO EMSB.

NOTE: If the accident involves an injury, hit and run, or property damage exceeding a combined total of $1,000 a report must be made to the police within 7 days.

Ambulance # 243-1706 ***May , 2005***

This list is to remain in ambulance.
Send separate list of changes to the Duty Office for revision.

Rear Upper Compartment Shelf # 1

12	Pillow Cases
24	Towels

Shelf # 2

24	Sheets
10	Kidney Basins
1 Box	Surgical Masks
1 Box	Splash Guard Visors

Rear Lower Compartment Shelf # 1

2	OB Kit (Side by Side)
12	Triangulars
14	8 x 10
1 Box	Zip Lock Bags
2 Boxes	4 x 4 Dressing
4	½" Tape
4	1" Tape
2 Boxes	2 x 2
2	2" Tape
12	Nose Clamps
12	Small Kling
12	Large Kling
50	Bandaids

Shelf # 2

12	Incontinence Pads
4	Shrouds
10	500ml Irrigation Solution
10	Hot Packs
10	Cold Packs
4	Burn Sheets
6	Burn Wraps 1"
6	Burn Wraps 3"
6	Burn Wraps 8"
12	Ear Plugs
1 Box	Gel Defib Pads

Middle Upper Compartment Shelf # 1

12	Extension Sets
12	Macro Sets
12 Each	IV Catheters: #14, 16, 22, 24
24 Each	IV Catheters: #18, 20
1 Box	2 x 2 Dressing
1	Small Combitube

Middle Upper Compart. # 2 Con't

1	Large Combitube
1	Trach Kit
2	Cricothyrotomy Kit / Batteries
3	Chest Decompression Kit
2	Nasogastric Tubes
2	60ml Syringe
6	D50 Barrels
6	Atropine Barrels
6	Adult Nebulizers
6	Child Nebulizers

Shelf # 2

6	Normal Saline 500ml
12	IV Locks
12	Lever Locks
24	Blunt Cannula
24	Needles 18g x 1½"
24	21g x 1½"
24	25g x 1½"
24	25g x 5/8
24	Tourniquet
½ Box	OP Site
1 Box	Alcohol Wipes
12	Saline 10ml
3	IV Tape
12	Syringe 1ml
12	Syringe 3ml
12	Syringe 10ml
1	Pressure Infuser
4	Normal Saline 1000ml
1 Box	Thermoscan Covers
1 Box	Lancets
1 Box	Test Strips
8	Oral Glucose
4	Pink Tape
6	Razor
3	EKG Paper
1	Spare Laryngoscope Blade # 3
1	Spare Laryngoscope Blade # 4
4	Defib Pads
4	Electrodes

Ambulance # 243-1706 ***May , 2005***

Middle Upper Compartment # 2 Con't	
1 Box	Gloves XL
1 Box	Gloves L
1 Box	Gloves Med
1 Box	Gloves Sm
Front Upper Compartment Shelf # 1	
6	O_2 Tubing
10	Adult NRB
10	Nasal Cannula
6	Pediatric NRB
6	Adult PPV Mask
6	Child PPV Mask
6	Infant PPV Mask
	Empty
2	McCreary Device
4	Suction Tubing 6ft
1	Spare BVM
Front Upper Compartment Shelf # 2	
2 Each	ETT # 6.0, 7.0, 7.5, 8.0, 9.0
6	Lubricating Jelly
6	ETT Stylets
3	CO2 Detectors
6	ETT Holders
5 Each	Nasopharyngeal Airway # 28
5 Each	Nasopharyngeal Airway # 30 & 32
6	Tonsil Tip Suction
4 Each	Child Sm OPA # 55,60,70,80
2 Each	Child Sm OPA # 0,00,000
6 Each	Adult OPA # 100,105,115
3 Each	Suction Catheter # 14 & 18
3 Each	Suction Catheter # 12 & 10
3 Each	Suction Catheter # 8 & 6
Rear Right Interior Shelving Top Shelf	
4	Large Irrigation Saline
2	Blankets
2	Isolation Gown
2	Trauma Bears
Shelf # 2 (Middle)	
4	Large Irrigation Saline
2	C-Collar Infant
2	C -Collar Pediatric
3	C-Collar No Neck
3	C-Collar Short
3	C-Collar Tall

Shelf # 3 (Bottom)	
1	Trauma Bag
Oxygen Cabinet	
12	Small Garbage Bags
6	Large Garbage Bags
1	Percept - Spare
1	Deodorizer - ProLink
Under Jump Seat	
1	Pedi - Mate
3	Disp. Wall Mount Suction Container
Cab	
1	IPAC
2	Pager
2	Radio
Compart. Behind Driver Seat	
2	Drug Kits (Green Tagged)
Compart. Behind Passenger Seat	
Rear Left Exterior Compartment	
2	Long Boards
2	Head Blocks
1	Scoop Stretcher
Rear Right Exterior Compartment	
1	Stair Chair
1	KED

CITY OF WINNIPEG FIRE PARAMEDIC SERVICE
VEHICLE CHECKLIST

Vehicle # ______________ Station # ______________ Call Sign # ______________

Mileage: ______________ Service Due: ______________

	DESCRIPTION OF PROBLEM
1) Check operation of all chassis lights, high and low beam, park lights, tail lights, brake lights, signal lights, back up lights, alarms, marker lights, running lights where applicable.	
2) Check operation of all emergency lights, beacons, flashers, loading lights, strobes, spot lights, left and right scene lights where applicable.	
3) Check operation of turn signals, four-way flashers, windshield wipers and washers, front heating or A/C system, horn, siren, radio, gauges or warning lights, dash lights, map lights, anti-theft. Check air horns, tachometer and throttle where applicable.	
4) Check all fluid levels – gas, oil (cold), transmission (hot), power steering, coolant recovery system, batteries, windshield washer and extinguishers.	
5) Check condition of battery cables, radiator and heater hoses, belts and wiper blades.	
6) Check patient compartment for operation of interior lights, heater or A/C system where applicable. Check invertor and electric heater where applicable. Note new or additional interior damage.	
7) Check exterior for; inflation and condition of all tires, fluid leaks, body damage or loose moulding.	

Additional information and deficiencies:

Driver: ______________ Officer: ______________ Date: ______________

Attendant: ______________ Shift: ______________

TO BE FORWARDED TO LIGHT FLEET MECHANICAL SERVICES

(CW:102 07)

Winnipeg Fire Paramedic Service

Paramedic Thrombolytic Therapy Checklist for Ischemic Stroke

Incident # ______________________________ Date ________________________

Patient Name ____________________________ Paramedic # __________________

Paramedic to indicate N (no) or Y (yes) beside each inclusion and exclusion criteria. If unable to assess, indicate U (unable) beside the contraindication.

INCLUSION CRITERIA

___ Age 18 years or older

___ Clinical diagnosis of ischemic stroke causing a measurable neurological deficit

___ Definite time of symptom onset well established to be 1 hour or 60 minutes prior to calling EMS.

EXCLUSION CRITERIA

___ Only minor or rapidly improving stroke symptoms

___ Active internal bleeding (e.g., gastrointestinal bleeding or urinary bleeding within last 21 days)

___ Within 3 months of intracranial surgery, serious head trauma, or previous stroke

___ Within 14 days of major surgery of serious trauma

___ Recent arterial puncture at noncompressible site

___ Lumbar puncture within 7 days

___ History of intracranial hemorrhage, arteriovenous malformation, or aneurysm

___ Witnessed seizure at stroke onset

___ Recent acute myocardial infarction

Paramedic Signature: ____

MD Signature / Comments: ____________________________________

Winnipeg Fire Paramedic Service

Paramedic Thrombolytic Therapy Checklist for Acute Myocardial Infarction

Incident # ______________________ Date ______________________

Patient Name ______________________ Paramedic # ______________________

Paramedic to indicate N (no) or Y (yes) beside each absolute or relative contraindication. If unable to assess, indicate U (unable) beside the contraindication.

Absolute Contraindications

___ Previous hemorrhagic stroke at any time

___ Other strokes or cerebrovascular events within 1 year

___ Known intracranial neoplasm, aneurysm, or AV malformation

___ Active internal bleeding (except menses)

___ Suspected aortic dissection

Cautions: Relative Contraindications

___ Severe uncontrolled hypertension at presentation (Blood pressure greater than 180/110)

___ Other intracerebral pathology

___ Current use of anticoagulants, known bleeding diathesis

___ Recent significant trauma (2 - 4 weeks), including head trauma

___ Prolonged (more than 10 minutes) and potentially traumatic CPR

___ Major surgery (less than 3 weeks prior)

___ Noncompressible vascular punctures (central lines)

___ Recent (2 - 4 weeks) internal bleeding

___ For streptokinase / anistreplase: prior exposure (especially in previous 2 years); prior allergic reaction to streptokinase

___ Pregnancy, childbirth within 6 weeks

___ Active peptic ulcer

___ History of chronic severe hypertension

Paramedic Signature: ____

MD Signature / Comments: ____

Date: ______________________

Ordered By: ______________________

Winnipeg Fire Paramedic Service Stores Order

Station: 31

ARTICLE	Bar#	Qty	ARTICLE	Bar#	Qty	ARTICLE	Bar#	Qty	ARTICLE	Bar#	Qty
AIRWAY & BREATHING			Nasogastric Tube 16 F	6532		Res-Q-Vac Replace Canister	6508		IV – NaCl 10 ml	3423	
McCreary Device	6473		Heimlich Valve	6430		Mask / Visor Fluid Shield	10990		IV – NaCl 500 ml	10996	
Uncuffed ETT			Heimlich Valve Connecting Tube	6431		Mask Fluidshield	6472		IV –NaCl 1000 ml	10995	
ETT - 2.0	6393		Nasopharyngeal 28F	3400		Sterile Gloves Size 8	6423		TAPE – 1" Surgical	6551	
ETT – 2.5	6392		Nasopharyngeal 30F	3401					TAPE – 1" Elastoplast	6550	
ETT – 3.0	6394		Nasopharyngeal 32F	3402		**Safety Equipment**			Sharps Container Sm	6519	
ETT – 3.5	6395		Oropharyngeal Size 0	6309		Gloves Nitrile – Sm	9411		Sharps Container L	6518	
ETT – 4.0	6396		Oropharyngeal Size 00	3403		Gloves Nitrile – Med	9412		Sharps Container XL	3393	
ETT – 4.5	6397		Oropharyngeal Size 1	6310		Gloves Nitrile – Lg	9413		**10 CC** Syringe	6547	
ETT – 5.0	6399		Oropharyngeal Size 2	6311		Gloves Nitrile –X-Lg	9414		**3 cc** Syringe	6546	
ETT – 5.5	6400		Oropharyngeal Size 3	6312		Gloves Conform – Sm	?		**1 cc** Syringe	6545	
ETT – 6.0	6402		Oropharyngeal Size 4	6313		Gloves Conform – Med	?		60 cc Syringe	10993	
ETT – 6.5	6404		Oropharyngeal Size 5	6314		Gloves Conform – Lg	?		Needle **18g x 1 1/2"**	6479	
Cuffed ETT			Oropharyngeal Size 6	6315		Safety Goggle	2928		Needle **20 g x 1 1/2"**		
ETT - 5.0	6398		Nasal cannula	6477					Needle **21 g x 1 1/2"**	6480	
ETT - 5.5			Kidney Basin	6451		**IV EQUIPMENT**			Needle **25 g x 1 ½"**	6481	
ETT - 6.0	6401		Melcher Cric Kit	6372		IV Admin Set Macro	10988		Needle **25 g x 5/8"**	6482	
ETT - 6.5	6403		Adult – NRB Mask	3413		IV Buretrol Micro	6439		4-Way Stopcock	6533	
ETT - 7.0	6405		Pediatric– NRB Mask	1098		IV Armboard	6438		Pressure Infuser	6447	
ETT - 7.5	6406		Nebulizer Mask Adult	3411		IV Extension	10989		**ECG SUPPLIES**		
ETT - 8.0	6407		Nebulizer Mask Pediatric	3412		IV Mini Extension	6446		Quik Combo Pads **Adult**	6382	
ETT - 9.0	6408		O2 Connecting Tubing	6489		IV CATH 14g 3 1/4"	3362		Quik Combo Pads **Pediatric**	6385	
ETT Holder [A]	3379		PPV Mask Adult	3415		IV CATH 14g 2"	3363		Electrodes **Adult**	12040	
ETT Holder [P]	3380		PPV Mask Child	3416		IV CATH 16g 1 1/4"	3364		Electrodes **Pediatric**	6384	
ETT Stylet [A]	6409		PPV Mask Infant	3417		IV CATH 18g 1 1/4"	3365		Recording Paper – LP12	10991	
ETT Stylet [P]	6410		Suction Cath. 18F	6539		IV CATH 20g 1"	3366		Defibrillator Battery – LP12		
Combitube Adult- small	3375		Suction Cath 14F	6538		IV CATH 22g 1"	3367		Razors	6504	
Combitube Adult	3376		Suction Cath 12F	6537		IV CATH 24g 3/4"	3368		**TRAUMA SUPPLIES**		
Entidal CO2 **[A]** Colormetric	6386		Suction Cath 10	6536		I.O. Needle 16g	6483		Bandage Comform 4"	6328	
Entidal CO2 **[P]** Colormetric	6387		Suction Cath 8F	6541		TOURNIQUET	10994		Bandage Confirm 6"	6326	
ETCO2 LP12 ETT Filter	6388		Suction Cath 6F	6540		OPSITE IV Dressing	6440		Dressing 2 x 2	6375	
ETCO2 Lp12 Nasal filter	6390		Suction Cath Tonsil Tip	6542		ALCOHOL WIPE	2848		Dressing 4 x 4	2879	
ETCO2 LP12 Humid Filter	6389		Suction Tubing	6544		INTERLINK Leverlock	6442		Dressing 8 x 10	2882	
Lubricating Gel Small	6466		Res-Q-Vac Suction Set	6507		INTERLINK Injection Site	6444		Bandaids	2859	
						INTERLINK Syringe Cannula	6445		Triangulars	2862	

Station # 31

Date:

ARTICLE		QTY	ARTICLE		QTY	ARTICLE		QTY	ARTICLE		QTY
Nose Clips	6485		Batteries 9v	1458		**STATIONARY**			**MAJOR EQUIPMENT**		
2"Tape	5085		Glucometer Battery	6331		Paper Clips	3286		Laryng Blade Mac 4		
1" Tape	8897		Laryngo Bulb Fiberoptic	6462		Computer Paper - Dispatch	4187		Laryng Blade Mac 3		
½" Tape	9901		Incontinence Pad	10987		Scotch Tape Refill	3233		Laryng Blade Mac 2		
Irrigation NaCl 500 ml	6434		Insect Repellent	10603		Erasers Pink-N-Ink	6653		Laryng Blade Mac 1		
Irrigation NaCl 1000 ml	6435		Penlights	3420		Hiliters	6787		Laryng Blade Millar 0		
Burn Sheet	6357		Sterile Drape	6556		Pens Black - Medium	7035		Laryng Blade Millar 1		
Burn wrap 1"	3358		Trauma Teddy	N/A		Writing Pads	7141		Larng Blade Millar 2		
Burn Wrap 3"	3359		OB KIT	6486		Ruler	7087		Laryng Handle Fibreoptic		
Burn Wrap 8"	3360		Ziplock Bags Medium	4305		Staples	3317		BVM Adult		
Cold Pack	6366		Ziplock Bags Large	4304		Stapler	7115		BVM Child		
Hot Pack	3410		Shrouds	6521		Rubber Bands	7080		BVM Infant		
C-Collar Pediatric	9996		Kleenex	10973		Push Pins	3310		BVM Reservoir		
C-Collar Infant	6367		Flares	2981		Correction pens	6623		Thermometer Tympanic		
C-Collar **No Neck**	3370		Toilet Paper	2124		Correction Dryline	3249		Oximeter Probe Infant Portable		
C-Collar **Short**	3372		Paper Towels [Rolled]	9092		Glue Stick	3271		Oximeter Probe Adult Portable		
C-Collar **Regular**	3371		Windshield Washer Fluid	10974		Markers Black	6855		ECG Trunk Cable – LP12		
C-Collar **Tall**	3373		O2 Key			Pencils	11097		Limb Wires LP12		
			Shears	6520		Liquid Paper Correction	3248		Precordial – 6Ld LP12		
DRUGS			Garbage Bags Grn – Lg	7555		Notebook Black	6880		Sat Probe Adult – LP12		
CALCIUM GLUCONATE			Garbage Bags Grn – Sm	7554		Xerox Paper Letter Size	10212		Sat Probe Extention–LP12		
INSULIN			Contamination Bags – CLEAR	7556		Xerox Paper Legal Size	N/C		Therapy Cable LP12		
LIDO SPRAY TIP			Incident Report Ambulance			.HP 56 INK CARTRIDGE	N/C				
MISC. SUPPLIES			**CLEANING SUPPLIES**			HP 57 INK CARTRIDGE	N/C		**OTHER**		
Glucometer Test Strips	3422		Precept Spray	7621		Gel Pens	12222				
Lancets Fingerstix	3386		ACCEL STF	7684		Gel Pen Refill	12223				
Themometer Probes	10984		Hand Cleaner 4 oz	7565		Hanging Folder Letter	6668				
Lancing Device	3387		Hand Cleaner 1000 ml	7564		Hanging Folder Legal					
Oral Glucose	3419		Cleaner Orange Plus	7531		File Folder Letter	6668				
Infant Suction Bulb Syringe	3425		Glass Cleaner	7527		Eraser	6654				
Feeding Tube 8F	6412		Enviro Plus Cleaner	7529		Post-it 1-1/2 x 2"	3281				
Cord Clamps Obstetrical			Toilet Cleaner Duck	7674		Post-it 3 x 3	3282				
Batteries AA	1453		Hand Cleaner Grime-Eater	7650		Post-it 3 x 5	3283				
Batteries AAA	1454		Lysol Cleaner			Post-it 3 x 5 ruled	11654				
Batteries C	1455		Odor Counteractant								
Batteries D	1456		PROLINK (deodorizer)	9905							

F14:95 05

CITY OF WINNIPEG FIRE PARAMEDIC SERVICE

STATION NO. ____________ PLATOON NO. ____________ № 26797

ANNUAL LEAVE
GROUP NO. ________

APPLICATION FOR LEAVE OF ABSENCE

______________________ 20 ____

CHIEF OF FIRE DEPARTMENT

SIR:

I hereby make application for { change of { ____________ Leave from Group No. ________ to Group No. ________ / from ______________________ to ______________________ / ________ weeks ________ days ________ hours ________ minutes leave of absence } under

the conditions prescribed by the Rules and Regulations governing the Fire Department, commencing at ______________ o'clock on

the ______ day of ______________ 20 ____, returning at ________ o'clock on the ________ day of ______________ 20 ____

for the purpose of { ______________________ / ________ weeks Annual Leave

and ______________________ Reg. No. ________ of No. ______ Station, Platoon No. ________, will substitute for me.

Respectfully submitted,

______________________ LIEUT. OR CAPTAIN

______________________ Reg. No. ________ APPLICANT

______________________ Reg. No. ________ SUBSTITUTE

Approved and Forwarded ______________________ DISTRICT CHIEF

Approved ______________________ PLATOON CHIEF

F14:95 05

CITY OF WINNIPEG FIRE PARAMEDIC SERVICE

STATION NO. ________ PLATOON NO. ________ № 26797

ANNUAL LEAVE
GROUP NO. ________

APPLICATION FOR LEAVE OF ABSENCE

________ 20____

CHIEF OF FIRE DEPARTMENT

SIR:

I hereby make application for { change of { ________ Leave from Group No. ________ to Group No. ________ / from ________ to ________ } / ________ weeks ________ days ________ hours ________ minutes leave of absence } under

the conditions prescribed by the Rules and Regulations governing the Fire Department, commencing at ________ o'clock on

the ________ day of ________ 20____, returning at ________ o'clock on the ________ day of ________ 20____

for the purpose of { ________ / ________ weeks Annual Leave

and ________ Reg. No. ________ of No. ________ Station, Platoon No. ________, will substitute for me.

Respectfully submitted,

________ LIEUT. OR CAPTAIN

________ Reg. No. ________ APPLICANT

________ Reg. No. ________ SUBSTITUTE

Approved and Forwarded ________ DISTRICT CHIEF

Approved ________ PLATOON CHIEF

F14:95 05

CITY OF WINNIPEG FIRE PARAMEDIC SERVICE

STATION NO. ________ PLATOON NO. ________ № 26797

ANNUAL LEAVE
GROUP NO. ________

APPLICATION FOR LEAVE OF ABSENCE

________ 20 ____

CHIEF OF FIRE DEPARTMENT

SIR:

I hereby make application for { change of { ________ Leave from Group No. ________ to Group No. ________ / from ________ to ________ } / ________ weeks ________ days ________ hours ________ minutes leave of absence } under

the conditions prescribed by the Rules and Regulations governing the Fire Department, commencing at ________ o'clock on

the ________ day of ________ 20 ____ , returning at ________ o'clock on the ________ day of ________ 20 ____

for the purpose of { ________ / ________ weeks Annual Leave

and ________ Reg. No. ________ of No. ________ Station, Platoon No. ________ , will substitute for me.

Respectfully submitted,

________ LIEUT. OR CAPTAIN

________ Reg. No. ________ APPLICANT

________ Reg. No. ________ SUBSTITUTE

Approved and Forwarded ________ DISTRICT CHIEF

Approved ________ PLATOON CHIEF

EMS SHIFT SUMMARY REPORT

DATE: ____________________

PLATOON: ____________________

ASST. PLTN. CHIEF (NAME) ____________________

MEDICAL SUPERVISORS ON DUTY (#)
(**does not** include O/T) __________

M.S. ASSIGNED TO RESPONSE UNITS (#) __________

PARAMEDICS ON DUTY #
(**does not** include O/T) __________

PARAMEDICS OFF
SICK/FAMILY SICK # __________

PARAMEDICS OFF
VACATION / STATS # __________

PARAMEDICS OFF OTHER # __________
DESCRIPTION: EXAMPLE WCB, TRAINING
____
____

PARAMEDICS ON OVERTIME # __________

AMBULANCES ON DUTY # __________

AMBULANCES OFF DUTY
(REFERENCE GOG 3.3.4) __________

PACERS ON # __________

PLATOON: ____________________

PARAMEDICS ON DUTY #
(**does not** include O/T) __________

PARAMEDICS OFF
SICK/FAMILY SICK # __________

PARAMEDICS OFF
VACATION / STATS # __________

PARAMEDICS OFF OTHER # __________
DESCRIPTION: EXAMPLE WCB, TRAINING
____
____

PARAMEDICS ON OVERTIME # __________

AMBULANCES ON DUTY # __________

AMBULANCES OFF DUTY
(REFERENCE GOG 3.3.4) __________

PACERS ON # __________

COMMENTS: ____________________
____
____

EMERGENCY MEDICAL SERVICES
REQUEST FOR SHIFT CHANGE

TO: PLATOON CHIEF (EMS)

FROM: ________________________________ **EMPLOYEE Nº.** ____________

I request that you give consideration for a shift change between myself and ______________________________,

employee number ______________.

We have mutually agreed that he/she will work my day/night shift on ______________________________ (date)

and in return I will work his/her day/night shift of ______________________________ (date).

I do hereby state and agree that I will present myself for duty in place of ______________________________

on the day/night shift on ______________________________ (date).

SIGNED ______________________________ **EMPLOYEE Nº.** ____________

DATE ______________________

I do hereby state and agree that I will present myself for duty in place of ______________________________

on the day/night shift on ______________________________ (date).

SIGNED ______________________________ **EMPLOYEE Nº.** ____________

DATE ______________________

PLATOON CHIEF (EMS) NOTES:

RECEIVED ______________________________ (date)

APPROVED ______________________________ **DATE** ______________________

NOTE:

1. **This application must be completed in its entirely and personally handed by the applicant to Platoon Chief (EMS) before the end of the tour of duty immediately prior to the tour of duty containing the requested change.**
2. **All sections of this form must be completed prior to it being presented to the Platoon Chief (EMS) and it will only be deemed to be approved when the Platoon Chief (EMS) has signed it and returned the appropriate copies to the applicant.**
3. **Both the requested change and payback be completed within a 32 day period from the date of the original shift change.**
4. **The Department will not accept any financial responsibility for shift changes.**

PLATOON CHIEF (EMS) - WHITE **APPLICANT 1 - CANARY** **APPLICANT 2 - PINK**

CW127: 2003 03

CITY OF WINNIPEG
REQUEST FOR MEDICAL INFORMATION

EMPLOYEE NAME:

AUTHORIZATION: (to be completed by the Employee)

I hereby authorize the treating medical practitioner to complete this form regarding my work capabilities.

Employee Signature ______________________ Date: ______________
(mm/dd/yyyy)

TO BE COMPLETED BY ATTENDING PHYSICIAN ***Please Print***

Providing the information requested below will assist the City of Winnipeg in accommodating this employee.

I Please check your patient's work related restrictions/limitations as the City of Winnipeg can generally accommodate most restrictions/limitations.

- ☐ 100 Above Shoulder Work
- ☐ 101 Balancing
- ☐ 102 Climbing Ladders
- ☐ 103 Climbing Stairs
- ☐ 104 Cognitive Ability
- ☐ 105 Crawling
- ☐ 106 Crouching/Stooping
- ☐ 107 Environmental Factors
- ☐ 108 Hearing
- ☐ 109 Kneeling
- ☐ 110 Lifting – up to 10 lbs.
- ☐ 111 Lifting – up to 15 lbs.
- ☐ 112 Lifting – up to 20 lbs.
- ☐ 113 Lifting – up to 50 lbs.
- ☐ 114 Lifting – over 50 lbs.
- ☐ 115 Manual Dexterity
- ☐ 116 Pulling
- ☐ 117 Pushing
- ☐ 118 Reaching- either or both arms
- ☐ 119 Shift Work
- ☐ 120 Sitting
- ☐ 121 Squatting/Bending
- ☐ 122 Standing
- ☐ 123 Use of Both Feet
- ☐ 124 Use of one of both Hands/Arms
- ☐ 125 Use of Respirator
- ☐ 126 Violent Confrontation - Avoid
- ☐ 127 Visual Acuity / Colour
- ☐ 128 Walking/Distance or Time
- ☐ 129 Walking/Uneven Ground
- ☐ 130 Working Alone
- ☐ 131 Working in Confined Space
- ☐ 132 Other
- ☐ xxx Driving

II Please describe further those items checked (e.g. sitting – sit up to 1 hour)

____

____

____

III Anticipated duration of restrictions/limitations: ______________________

IV Please indicate this employee's capability to perform their regular or alternate duties:

A ____ Able to resume full regular duties ______________________
(mm/dd/yyyy)

OR

B ____ Able to resume modified regular duties or alternate duties which accommodate the restrictions or limitations for the duration and frequency outlined above ______________________
(mm/dd/yyyy)

C ____ Not fit to return to regular duties/any modified duties ______________ Specify reason
(mm/dd/yyyy)
this employee is unable to perform any work function: ______________________

____

Date of Examination ______________ Date of Next Examination ______________
(mm/dd/yyyy)

Medical Practitioner's Name: (Please Print) ______________________

Address: ______________________ Signature: ______________________

THE CITY OF WINNIPEG
FIRE PARAMEDIC SERVICE

REQUEST FOR INFORMATION TECHNOLOGY SERVICES

REQUESTED BY:

APPROVED BY:

DATE OF REQUEST:

DATE REQUIRED:

DESCRIPTION OF REQUEST:

REASON FOR REQUEST:

ANTICIPATED BENEFIT:

BRANCH HEAD COMMENTS:

BRANCH HEAD SIGNATURE ______________________________

Pltn #_____ Stn #_____ Incident # ______________ Date: __________

Paramedic: ______________________________ Lic. # __________

Refusal of Treatment / Transport Documentation
GOG: 3.40
Documentation Omissions

The (√) items were MISSED in the initial PCR documentation

- ☐ Date, Time, and location where patient found
- ☐ Presenting complaint
- ☐ History and physical examination, including vital signs
- ☐ Mental status exam
- ☐ Alert and orientated to person, place, time, and events
- ☐ Patient does not appear to be under the influence of alcohol, Drugs, or other substances or injuries that may impair ability To make decisions
- ☐ Patient is clearly not a risk to self or others
- ☐ Reason(s) for refusal
- ☐ Consequences of refusal of care reviewed with patient
- ☐ Information on how to contact EMS if patient changes mind
- ☐ Other advice given to the patient
  - ☐ Identification of police on scene (if applicable)
  - ☐ Name of family member or other adult present as witnesses
  - ☐ Record name of person(s) present with patient at disposition
  - ☐ Who called 911 and why (if available)
- ☐ Copy of the refusal of care form not signed or "reasons why" not identified
- ☐ Other: ____

Please Return to Medical Supervisor when completed

Pltn #_____ Stn #_____ Incident # ______________ Date: __________

Fire Medic / First Responder:________________________ Reg# # ___

***Medical Supervisor:* ________________________________ *Pltn. #* ___________**

Refusal of Treatment / Transport Documentation

GOG: 3.40

Documentation Omissions

The (√) items were MISSED in the initial PCR documentation

- ☐ **Date, Time, and location where patient found**
- ☐ **Presenting complaint**
- ☐ **History and physical examination, including vital signs**
- ☐ **Mental status exam**
- ☐ **Alert and orientated to person, place, time, and events**
- ☐ **Patient does not appear to be under the influence of alcohol, Drugs, or other substances or injuries that may impair ability To make decisions**
- ☐ **Patient is clearly not a risk to self or others**
- ☐ **Reason(s) for refusal**
- ☐ **Consequences of refusal of care reviewed with patient**
- ☐ **Information on how to contact EMS if patient changes mind**
- ☐ **Other advice given to the patient**
  - ☐ **Identification of police on scene (if applicable)**
  - ☐ **Name of family member or other adult present as witnesses**
  - ☐ **Record name of person(s) present with patient at disposition**
  - ☐ **Who called 911 and why (if available)**
- ☐ **Copy of the refusal of care form not signed or "reasons why" not identified**
- ☐ **Other: ____**

(When documentation omissions completed. Please return to the Platoon Chief)

Winnipeg
Fire Paramedic Service

PITNEY BOWES
COPIER READING
FAX 1-877-637-9754

ACCOUNT #	011270441308
MODEL #	9725
SERIAL #	1034069
READING	------------ -

FIRE PARAMEDIC SERVICE
PHARMACEUTICAL INVESTIGATION REPORT

INVESTIGATION REPORTS ARE TO BE COMPLETED BY THE ASSISTANT PLATOON CHIEF (EMS) FOR ALL INCOMPLETE / INACCURATE PHARMACEUTICAL INVENTORY CARDS.
PLEASE ATTACH A COPY OF THE ORIGINAL PHARMACEUTICAL INVENTORY CARD.
COMPLETE FORM AND FORWARD TO THE PLATOON CHIEF (EMS).

PHARMACEUTICAL KIT IDENTIFICATION NUMBER:

DATE:________ **INCIDENT NUMBERS:**______,______,______,______,______,________

TIME:________
MEMBERS INVOLVED:____

INCOMPLETE / INACCURATE DOCUMENTATION:_____
MISSING PHARMACEUTICAL KIT: _____
INVENTORY CARD / PCR DISCREPANCIES: _____
DISCREPANCIES REPORTED BY PARAMEDIC: _____

DETAILS:____

____

____

____

____

ACTION TAKEN: ____

____

____

____

____

____

REQUIRES FURTHER INVESTIGATION: YES:_____ **NO:**_______
IF YES, REPORT TO BE FORWARDED TO PLATOON 1 / 2 / 3 / 4 (circle one)

Assistant Platoon Chief Signature:________________________ **File Closed (Date):**__________

Platoon Chief Signature:________________________________

The City of Winnipeg
Fire Paramedic Service

PHARMACEUTICAL EXPIRATION RECORD

Date Received	Received From	Pharmaceutical Name	Expiry Date	Destruction Date	Initials

Disposed of by: ______________________________ Assistant Platoon Chief (EMS)

______________________________ Stores Personnel

______________________________ Date

Date Opened: ______________

PCR AUDIT

Name: ____________________________ Unit # _______ Pltn # ____

INCIDENT #: EMS ________________________ N/A ☐

Transport ☐ No Transport ☐

Commendation ☐ Appropriate Documentation ☐

Medical Concern ☐ Protocol Concern ☐

Documentation Concern ☐

	Opener	Closer		Opener	Closer		Opener	Closer		Opener	Closer
Brown			Hemmerling			Thomas			K.Brown		
Clear			Johnson			Tinguely			Downes		
Dacquay			Roberts			Ulrich			Desmond		
Ford			Ross			Wiebe					

Concern /Observations: ____

____

____

____

____

____

____

____

Continued on Reverse ☐

Action: None Required ☐ To File ☐ Review with Platoon # _______ Medical Supervisor

Resolution: *Referred to:* *N/A* ☐ *Training* ☐ *Medical Director* ☐

____

____

____

____

____

____

Continued on reverse ☐

Date : ______________________

Return to Originator when closed

CONCERN / OBSERVATIONS (CONT.)

RESOLUTIONS: (cont)

Name: ____________ **Reg. #** ____________ **Date:** ____________

PARAMEDIC FEEDBACK:

Signature: ____________ Date: ____________

Medical Director / Training Response

Signature: ____________ Date : ____________

Return to Originator when closed

FIRE PARAMEDIC SERVICE
PARAMEDIC ABSENCE REPORT

TO BE COMPLETED BY ASSISTANT PLATOON CHIEF ON THE ABSENCE OF AN EMPLOYEE FOR ANY REASON.

PLEASE COMPLETE THIS FORM AND FORWARD IMMEDIATELY TO THE EMS PAYROLL SUPERVISOR.

EMPLOYEE NAME:			
VACATION		LEAVE OF ABSENCE W/PAY	
STAT		WORKERS COMP	
SICKNESS		WEEKLY INDEMNITY	
SICKNESS (FAMILY)		BEREAVEMENT (*)	
LEAVE OF ABSENCE W/OUT PAY		UNION LEAVE	
OTHER:			

DATE(S) ABSENT:

IF ABSENT FOR PART OF A DAY, STATE HOURS:

ASSISTANT PLATOON CHIEF SIGNATURE	DATE

Recorded ☐

**** THIS SECTION MUST BE COMPLETED FOR BEREAVEMENT LEAVE***

RELATIONSHIP OF DECEASED TO EMPLOYEE	
DATE OF DEATH	
LOCATION OF FUNERAL	
DATE OF FUNERAL	
EMPLOYEE SIGNATURE:	DATE:

FOR OFFICE USE ONLY:	
DAY OF WEEK:	DAY OF TOUR:

Recorded ☐

c:forms/absence.rpt
Revised: 27/09/05

F.73 (03 03)

WINNIPEG FIRE PARAMEDIC SERVICE
OVERTIME REPORT

Date ______________________

Overtime worked on ________ ________ ________ ________
Year Month Date Hour

Branch ____________________ **Station** ______ **Platoon No.** _____ **Apparatus/Unit No.** ______

This overtime claim results from:

ALARM OF FIRE ______ MEDICAL ______ TRANSFER ______ AWAITING REPLACEMENT ______

COURT APPEARANCE ______ CALL IN ______ OTHER(Explanation) ______________________

If dispatch related: Incident No.____________ Address ______________________

Details of Overtime: ______________________

____

OVERTIME:

Employee/ Reg.No.	Rank or Classification	Name	Off Duty Time	OFFICE USE ONLY: MLA	Travel Time	Hours @ T½	Hours @ D.T.	Hourly Rate

AWAITING REPLACEMENT/CALL IN RELATED OVERTIME:

Employee/ Reg.No.	Rank or Classification	Name		Changeover Time	OFFICE USE ONLY: Travel Time	Hours @ T½	Hours @ D.T.	Hourly Rate
			Called In					
			Held Over					

Submitted by ______________________ Reg.No. ________ Rank/Classification ______________________

Checked by ______________________ Reg.No. ________ Platoon Chief/District Chief/Assistant Platoon Chief

Approved by ______________________ Branch Head/Assistant Chief

Paid on Pay Period No. ______ Ending ______________

____
Certified Correct - Payroll

CW740: 2003 03

Observer's Application Form

Date: ________________

To be completed by Applicant:

Name: ______________________

Address: ____________________

Phone. No: __________________

Sponsor Institution/Agency:

____

Phone No.: __________________

Reason for Ride-Along:

____

Request **Approved / Denied** by:

____

WFPS Authorized Signature

Scheduled to observe on:

Date: ________________

Time: ________________

Location: ______________

Protocol for Riding in a WFPS EMS Vehicle as an Observer:

- The applicant must obtain signed approval from a senior WFPS officer .
- Waiver forms must be signed by the Observer and must be returned to WFPS, 5th Floor, 151 Princess Street at least 24 hours in advance.
- Applicant must be at least eighteen years old.
- Applicant will be restricted to one shift a year unless special circumstances exist.
- Riding as an observer is not considered a substitute for preceptorship in accredited training programs.
- Observers must adhere to the following:
  - Appearance must be neat and well groomed. Departmental uniform if representing another Emergency Service organization (suggested dress codes: Dark slacks, blue or white shirt and dark coloured footwear).
  - Observers will not engage in any patient contact, unless sanctioned by the goals and objectives of their agreed upon rotation.
  - Observers will not be permitted to drive a WFPS Ambulance vehicle, or operate any equipment belonging to the WFPS.
  - The Duty Staff Inspector will withdraw an observer's ride-along privilege for breach of protocol, improper conduct, or any other valid reason.

As a condition of this ride-along, I understand that my obligations concerning the protection of anyone's personal health information (PHI), which I may learn, relate to all PHI I may acquire through this association with the WFPS. I understand that I am obliged by the Personal Health Information Act (PHIA) to keep that information confidential.

______________________ ______________________

Observer's Signature Date

This form must be kept on file for future references and attached to appropriate release forms.

Winnipeg Fire Paramedic Service

MEDICATION INCIDENT REPORT

Please Print when completing this form

Incident #: ______________ **Incident Time** ___ : ___ [24hr] **Date:** [dd/mm/yy] _____/_____/_____ **Unit #** _____
Charge Paramedic : __________________ #: _______ **Assisting Paramedic :** __________________ #: _______
Signature of Reporting Paramedic: __________________________ # _______ ***Date:*** {dd/mm/yy] _____/_____/_____

Patient Affected: O N/A

Surname: ______________________________ Given: ______________________________
Home Address: ______________________________ City ______________ Prov. __________
Postal Code: __________ Phone: ______________ Date of Birth [dd/mm/yy] _____/_____/_____
MHSC #: ______________ PHIN # ______________________

Type of Incident: [Check all that apply]

O Medication O Rate of Administration
O IV Fluid O Tissue Infiltration
O Drug Count O Narcotic / Controlled Drug

Route of Administration: O N/A

O PO O SC O ETT O Rectal
O IM O IV O Combitube O SL
O Other: [specify] ______________________________

Degree of Injury:

O Non-apparent O Slight – No Treatment O Moderate – First Aid O Serious – Treatment Required O N/A

Reason: [check all that apply]

O Wrong drug O Wrong Rate O Wrong Route O Wrong Dose O Wrong Time O Allergy O Other

Description of Incident & Immediate actions taken:

____
____
____
____
____
____
____
____

Contributing Factors: O N/A

O Wrong Label O Failure to check expiry date O Calculation error
O No Label O Inadequate monitoring of IV rate O environmental concerns
O Failure to confirm Drug O Protocol error O Equipment malfunction
O Other: [specify] ____
____

Complete reverse side

Notification Documentation:

Triage notified: O yes O no O N/A Name: ______________________

Receiving Physician notified: O yes O no O N/A Name: ______________________

Asst Pltn. Chief notified: Name: ______________ Time: ____:____ [24hr] Date [dd/mm/yy] ___/___/___

[signature] ______________________

Medical Director notified Name: ______________________ Date [dd/mm/yy] ___/___/___

Notified by: ______________________ Rank: ______________

Follow- up required : O yes O no **Remedial action required**: O yes O no:

Follow-up: *(Steps taken to arrive at conclusion)*

Conclusions: *(Decision on cause of incident)*

Remedial Action(s): *(Steps required to prevent reoccurrence)*

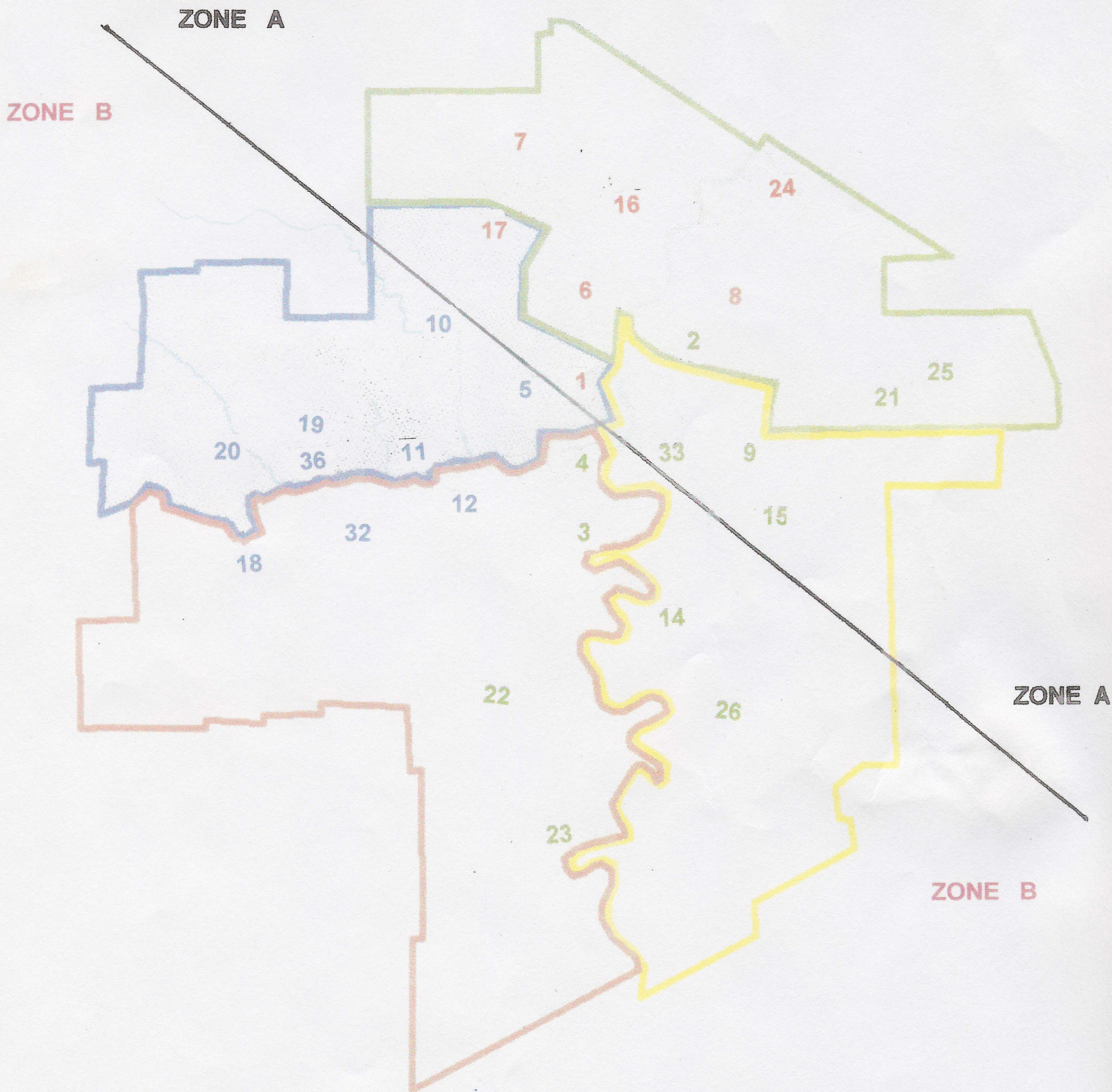
Remedial Action	Assigned to	Date

Medical Director / Designate: ______________________ *Date:* ______________

Signature *[dd/mm/yy]*

"A copy of this completed form is to be returned to the Medical Supervisors Office"

Medical Supervisor Zones



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73

75

Mass Casualty Trailer Supply Inventory (August 12, 2005)

Department of National Defence / Civil Defence Supplies

1- Casualty Collecting Unit(Provides first-aid treatment for 500 casualties at the resucue site and facilitates casualty evacuations to the supporting Advanced Treatment Centre)

CAT. No.	Item Name	Quantity Present	DND Inventory
5-1128 Re-Packed 1990	Alum. Pole Stretcher	64	64
8-430 Re-Packed 1990	Grey Blankets, G.S.	95 (-35)	130
8-450 Packaged 1967	Bottle, Water, Canteen	30 (-21)	51
8-850 Packaged 1963	Haversack, First-Aid Kit	45 (-3)	48
8-9051 Packaged 1990	CCU No. 1	1 (incomplete) *	1
8-9052 Packaged 1954	CCU No. 2	3 (1 incomplete)*	3

*- See Technical Guide for Health Supplies Officers

WFPS Supplies

MCI Drop Kit 1

- -100 4x4 dressings
- -50 2x2 dressings
- -18 8x10 dressings
- -40 small kling
- -12 large kling
- -24 triangulars
- -1bx m/l gloves
- -1bx isolation masks
- -1bx bandaids
- -1bx defib pads
- -4 shrouds
- -12 roll IV Tape

Mass Casualty Trailer Supply Inventory (August 12, 2005)

Back Boards (wood)	30
IV Catheters	…several hundred...no fluids/no admin sets

F2E

 Type of claim ________ ID # ________	________________________ **Name of Injured Employee** Stn.# ______ Pltn # _____ Reg # _______ Rank at time of accident:________________

Incident and Injury Form

(To be completed by Supervisor)

Answer Clearly - Please Print or Type
(Refer to Incident and Injury Form User Guide)

NOTE: Questions marked with an asterisk (*) must be completed when there is a WCB claim.

Office Use Only
(ii) PeopleSoft Incident Number: _____ (iii) WCB Claim Number: _____ (iv) PeopleSoft Claim Number:_____

(*1)	**What is the Incident Type?** **(Check only one)** (Definitions in User Guide Appendix A)	☐ Dangerous Occurrence ☐ Exposure ☐ Hazardous Condition ☐ Illness	☐ Injury ☐ Non Work Related (injury or illness) ☐ Safety Violation ☐ Vehicle Equipment Accident	
(*2)	**Date and time of the injury / incident**	Date:	Time:	☐ AM ☐ PM
(3)	**Exposure?** (Complete if exposure checked in Section A)	Start Date:	Start Time:	☐ AM ☐ PM
	Symptoms (Please describe if applicable)	End Date:	End Time:	☐ AM ☐ PM
(3a)	**Type of Protective Equipment (Used)**	☐ Gloves – Latex ☐ Gloves – Other ☐ Goggles ☐ Mask ☐ Other – Explain ________ ☐ Were protective barriers intact? If not, explain ________ ________		
(*4)	**Date/time reported to the Employer by the injured employee**	Date:	Time:	☐ AM ☐ PM
(*5)	**Reported To?** (In most cases this is the employee's supervisor)	First and Last Name: ________ Job Title: ________		

(*6)	**Description: Describe fully what happened to cause the injury** **See Section C - #6 in User Guide**	
(*7)	**Did the incident occur on City of Winnipeg premises?**	☐ Yes ☐ No FIRE INC# _________ EMS INC# _________
(*7a)	**Exact location of incident**	
(*8)	**Identify names of employees & non-employees involved in the incident & their roles.** (Definition of roles in User Guide Appendix B) * Witnesses only required for WCB claims. Provide two witnesses if possible.	Name(s) ID # _______________ _______________ _______________ Role(s) (e.g. witness) _______________ _______________ _______________
(*9)	**Provide the address for each witness (only if not a city employee)**	
(10)	**Witness # 1 statement confirmation** **Witness # 2 statement confirmation**	☐ Confirmed (Attach statement) ☐ Unconfirmed ☐ Unknown ☐ Confirmed (Attach statement) ☐ Unconfirmed ☐ Unknown
(*11)	**Was a Non-Employee responsible for incident?**	☐ Yes ☐ No If yes, then provide name Name:

If the incident did not result in injury, illness, or exposure to an employee, go to No. 22

(*12)	**What was the primary outcome of the Employee's injury, or illness?**	☐ Injury ☐ Illness ☐ Death Date of Death:
(*13)	**What was the outcome of the employee's injury, illness or exposure?**	☐ Health Care Only (Went to Dr. – no time loss, this form is required) ☐ Reported Only (no time loss, no medical treatment, this form is required) ☐ Time Loss (regular time loss from work) ☐ Fatality

		Body Part	Side of Body	Nature of Injury	Primary (✓ one)
(*14)	**Body Parts (Where did the employee sustain the injuries?)** **(State All Injuries Reported)** **(Describe using values in User Guide Appendix C)**		☐ front ☐ back ☐ right ☐ left		☐
			☐ front ☐ back ☐ right ☐ left		☐
			☐ front ☐ back ☐ right ☐ left		☐

			☐ front ☐ back ☐ right ☐ left		☐

(15)	**Type of Health Care** (Check only one)	☐ Physician	☐ Hospital		
(16)	**Full name and address of the physician**				
(17)	**Name of the Hospital or Medical Facility?**				
(*18)	**Last date / time the injured employee worked?**	Date:	Time:	☐ AM	☐ PM
(*19)	**Return Date / Start Time of the employee?** (Only if applicable)	Date:	Time:	☐ AM	☐ PM
(*20)	**Placement Type** (Check One) **(Only if applicable. Definitions in User Guide)**	☐ MR (Modified Position) ☐ WCR (Workers Compensation Rehabilitation Position) ☐ AR (Alternate Regular Position)			
(*21)	**WAGE INFORMATION TO BE COMPLETED BY OFFICE** **Employee's pay at time of incident** **Wages paid on the day of layoff** **Employee's normal days' pay** **Employee's gross earnings for the last calendar tax year**	 $ ________/hour $________/day $________/day $ ________			
(*22	**Were the actions work related?**	☐ Yes ☐ No If no, explain:			
(23)	**Identify the hazard(s) that were the primary cause of the incident. Describe using the values in User Guide Appendix E**	1st 3rd	2nd 4th		
(24)	**What were the contributing factors? Describe using values in User Guide Appendix F**	1st 3rd	2nd 4th		
(25)	**Employee responsible for completing the corrective action**	Name:			
(26)	**What is the status of the action?** (Check only one)	☐ Completed ☐ Existing ☐ In progress	☐ Legislated ☐ Planned	☐ Recommended ☐ Required	
(27)	**Action: (Describe corrective action taken by Supervisor)**				

(28)	**Recommended date for completion. (Estimated)**	Date:						
(29)	**Actual date of completion.**	Date:						
(30)	**What vehicle or equipment was involved in the incident?** (Values in User Guide Appendix G)	1st			2nd			
		3rd			4th			
(31)	**What are employee's normal days of rest? (Where days of rest vary, please attach a work schedule for the following 2-4 weeks).**	Sun. ☐	Mon. ☐	Tues. ☐	Wed. ☐	Thurs. ☐	Fri. ☐	Sat. ☐
(*32)	**Supervisor's Name** **(Must be Captain or Higher Ranking Officer)**	Print : ______ Signature: ______ Rank: ______ Date:______						
(33)	**Additional Comments** (if required)							

(34) **For Health & Safety Use Only:**
H & S Committee Co-Chairs (Signatures)

	Date:
	Date:

Date Opened: _____

FIRE AUDIT

FIELD AUDIT ☐ PCR AUDIT ☐

Name: ______________________ Training level _____ Unit # _____ Pltn

Incident Address: ______________________________ Date__________

INCIDENT #: _______________ N/A ☐

Patient Transported ☐ *No Transport* ☐

Commendation ☐ **Appropriate** ☐

Medical Concern ☐ **Protocol Concern** ☐

Documentation Concern ☐ **Other Concern** ☐ (explain)

	Opener	Closer		Opener	Closer		Opener	Closer		Opener	Closer
Brown			Hemmerling			Thomas			K.Brown		
Clear			Johnson			Tinguely			Downes		
Dacquay			Roberts			Ulrich			Desmond		
Ford			Ross			Wiebe					

Concern /Observations: ______________________________

Continued on Reverse ☐

Action: ☐ Nil ☐ Review with Pltn. #____Medical Supervisor ☐ Forward to Medical Director

Resolution: *Referred to:* *File* ☐ *Training* ☐ *Medical Director* ☐

Continued on reverse ☐

Date :__________ Signature: ______________________

Concern / Observation (Cont.)

Resolution (Cont)

Fire Medic / First Responder Feedback:

Medical Director / Training Response

Return to Originator when closed

Field / Communications Centre Feedback Report

(Please complete and forward to the QI Branch, Attn: Lori Shoemaker, 2nd fl., 185 King St. R3B 1J1, or fax 947-0164)

The purpose of this form is to submit feedback to/for the Communications Centre regarding a particular event, or to request analysis of an incident in order to provide clarification and/or further education.

Reported/Requested by: ________________________ **Branch/Agency:** _________________

Contact Phone# ___________ **Platoon #** __ **Station #**___ **Email** ___________________

(The above is so that you may be easily contacted with a response to your Feedback Report)

Incident Date: ____________________________ **Incident #:** __________________________

(e.g. 11-Apr-2005)

EMD: ___________________________________ **EMD:** ________________________________

Response Team: (name & position)

1. ____

2. ____

3. ____

4. ____

5. ____

Feedback / Problem Encountered:

____

____

____

____

____

____

____

Specific Protocol referred to: ____________________________________ **#:** __________

Operating procedure referred to: ________________________________ **#:** __________

QIB Use Only

Received at QIB: ______________________________ (e.g. 11-Apr-2005) **By:** ____________________

Investigation outcome / Action Plan:

____

____

____

____

____

____

Attachment(s): ***yes*** ☐ ***no*** ☐ **Review completed:** ___________________________ (e.g. 11-Apr-2005)

Compliance %: _______ **Correct Response Code**: _______ **Reported to:** ______________________

EMD-Qs signature: __________________________________ **Date:** __________________________

cc: Dr. R. Grierson, ________________________________, ______________________________

Date Opened: ____________

FIELD AUDIT

Name: ____________________________ Rank _________ Unit # _______ Pltn # ____

INCIDENT #: EMS ______________ FIRE_______________ N/A ☐

Location: ____ DX Code: ______

CQI ☐ Field request ☐ Dispatched ☐ Self Dispatched ☐ Hands on Care ☐

Transport ☐ *No Transport* ☐

Commendation ☐ Appropriate Care ☐

Protocol Concern ☐ Medical Concern ☐ Other Concern ☐

	Open	Close
Brown		
Clear		
Dacquay		
Ford		

	Open	Close
Hemmerling		
Johnson		
Roberts		
Ross		

	Open	Close
Thomas		
Tinguely		
Ulrich		
Wiebe		

	Open	Close
K.Brown		
Downes		
Desmond		

INCIDENT INFORMATION :

____

____

____

____

____

____

____

____

Continued on reverse ☐

Resolution: ***Referred to:*** *N/A* ☐ *Training* ☐ *Medical Director* ☐

____

____

____

____

Continued on reverse ☐

Date :________________

Return to Originator when closed

INFORMATION (cont)

RESOLUTION (cont.)

Signature: ______________________ Date: ______________

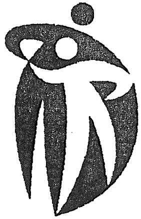
Paramedic Feedback:

Signature: ______________________ Date: ______________

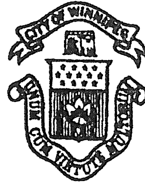
Medical Director / Training Response

Signature: ______________ Date : ______________

Return to Originator when closed



Winnipeg Regional Health Authority | Office régional de la santé de Winnipeg



CITY OF WINNIPEG
VILLE DE WINNIPEG
FIRE PARAMEDIC SERVICE
SERVICE D'INTERVENTION D'URGENCE

DESTINATION POLICY CASE REVIEW

DATE:______________________ AGENCY: WRHA ______ WFPS ______

TIME:______________________ SITE ______

Patients Initials:______________ EMS Incident Number:______________

Patients Hospital ID Number: ______________________

Description of Occurrence ____

____

____

____

____

____

Name of Person Completing Report:____________________ ____________________
Print Signature

Forward completed report to your immediate Supervisor

Case Review Received by:______________________________

Name :____________________ ____________________
Print Signature

Date:______________________________

Comments:____

____

____

Forward completed report to :
WRHA Emergency Program Fax: 787-2231

WRHA Review of Occurrence

Reviewed by:______________________________

Date:______________________________

Comments:____

____

____

November 28, 2000

Appendix A

PHARMACEUTICAL INVENTORY CARD

DATE	PHARMACEUTICAL	LOST	ADMIN	DISCARD	INC #	MEDIC #	PLTN #

______________________________ ASST. PLATOON CHIEF

______________________________ STORES

FORM AMB13: 02 11

WINNIPEG FIRE PARAMEDIC SERVICE
NARCOTIC FIELD INVENTORY CARD
ASSISTANT PLATOON CHIEFS' DRUG LOCK BOX

CARD #________________

DRUG:

YEAR:

ORDER POINT: ________________

ORDERED			QUANTITY					DISTRIBUTION		
DATE	QUAN.	ASST. PLTN. CHIEF INITIALS	DATE	IN	OUT	BAL.	ASST. PLTN. CHIEF INITIALS	ISSUED TO	PARAMEDIC INITIALS	ASST. PLTN. CHIEF INITIALS

Page 2

Friday: ______										
Paramedic	Start Time	Start Balance	Out	Bal	In	Stores Order	Used	Broken	Balance	Incident # For Drug usage
	0700									
	1900									

Saturday: ______										
Paramedic	Start Time	Start Balance	Out	Bal	In	Stores Order	Used	Broken	Bal anc e	Incident # For Drug usage
	0700									
	1900									

Sunday: ______										
Paramedic	Start Time	Start Balance	Out	Bal	In	Stores Orders	Used	Broken	Balance	Incident #'s For Drug usage
	0700									

WEEKLY AUDIT

Weekly Start ________ **Sub-Total** ________

Stores Orders +________ **Used** – ________

Sub-Total =________ **Broken** – ________

TOTAL = ____________

Signatures:

Paramedic: ______________________________ **Reg#** __________

Station Officer: ______________________________ **Reg#** __________

Date: __________________
Day / Month / Year

Return to the Assistant Platoon Chief at Station # 31

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Page 2

Friday: ______										
Paramedic	**Start Time**	**Start Balance**	**Out**	**Bal**	**In**	**Stores Order**	**Used**	**Broken**	**Balance**	**Incident # For Drug usage**
	0700									
	1900									

Saturday:										
Paramedic	**Start Time**	**Start Balance**	**Out**	**Bal**	**In**	**Stores Order**	**Used**	**Broken**	**Balance**	**Incident # For Drug usage**
	0700									
	1900									

Sunday: ______										
Paramedic	**Start Time**	**Start Balance**	**Out**	**Bal**	**In**	**Stores Orders**	**Used**	**Broken**	**Balance**	**Incident #'s For Drug usage**
	0700									

WEEKLY AUDIT

***Weekly* Start** ________ **Sub-Total** ________

Stores Orders +________ **Used** – ________

Sub-Total =________ **Broken** – ________

TOTAL = ____________

Signatures:

Paramedic: ______________________________ **Reg#** __________

Station Officer: ______________________________ **Reg#** __________

Date: ____________________
Day / Month / Year

Return to the Assistant Platoon Chief at Station # 31

© RBC

The City of Winnipeg
Fire Paramedic Service

NARCOTIC BREAKAGE/LOSS REPORT

Date: ____________________ **Time:** ____________________

Location: ____

Incident Number: ____________________ **Unit Number:** ____________________

Attending Paramedic: **/Licence No.**

Explanation:

Signatures:

Paramedic **Reg #**

Station Officer **Reg #** ____

Assistant Platoon Chief: ____________________ **Reg #** __________

City of Winnipeg Fire Paramedic Service

Commodities Request Form

Please Indicate Routing:

- ☐ Headquarters: includes Administration, Information Technology, Communications
- ☐ Fire Prevention
- ☐ Emergency Mechanical Service - Fire
- ☐ Emergency Mechanical Services - Paramedic
- ☐ Stores
- ☐ Academy - Fire
- ☐ Academy - Paramedic

☐ Item for Apparatus/Vehicle No: __________________ Station No.: ________________

☐ Item for Personnel...

Name: ___________________________ Reg. No. ______ Station: __________ Platoon: _________

☐ Item for Station Use Station No. _______________

Captain's/Staff Inspector's Name: _________________________________ Date: _________________

(Please Print)

Signature: _______________________________ Reg. No. _____________ (if applicable)

Particulars of Request: (*Please include size or part number, etc.*) ***Additional Information on Back***

____

____

____

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____

____

FOR OFFICE USE ONLY - DO NOT WRITE BELOW THIS BOX

Branch: ____________________ Date Received: ________________ Completion Date: ________________

Action Taken: ____

____

____

____

Signature: _________________________________

BRANCH MANAGER - FORWARD ORIGINAL TO DEPUTY CHIEF, SUPPORT SERVICES

CW969: 2002 05

Audiotape Transcript Request Form

Date transcript requested	

EMS incident number	
Fire incident number	

Date(s) of incident(s)	
Time(s) of incident(s)	

Person requesting tape	
Tape to be delivered to	
Date tape required	
Reason for tape	

What is required on the tape? (eg. original telephone call(s), subsequent call(s), radio communications)	

Person responsible for disposal of tape (re: PHIA)	

The City of Winnipeg
Fire Paramedic Service
Ambulance Staffing Record

Date: ________ **Platoon:** _____ & _____

24 Hour Paramedic Unit	Training Level
1	________
41	________
2	________
4	________
5	________
6	________
14	________
20	________
22	________
24	________
25	________
32	________
	________
	________
	________

Peak Paramedic Unit #	Peak Unit Hours of Operation & Training Level	
	10:00 – 22:00	12:00 – 00:00
31	________	________
16	________	________
36	________	________
45	________	________
17		________

IFT Paramedic Unit #	IFT Unit Hours of Operation & Training Level	
	08:00 – 20:00	12:00 – 00:00
10		________
33	________	
43	________	

Legend: A – ACP I – ICP P – PCP O/S – Out of Service