MEDICAL SUPPLY RECEIPT AND INVENTORY FORM

| INCIDENT NAME:INCIDE | | DENT #: | | |
|----------------------|---|----------------------|--------|--|
| A. | Supplies/Equipment received from : | DATE: | / / | |
| | Agency: Unit ID#: Name (Whenever possible, use masking tape and markers to ide | : ntify all equip | ment) | |
| B. | Supplies/Equipment Received by : | | | |
| NA | NAME: INCIDENT POSITION: | | | |
| No. | Item Description (Print All Entries) | Unit* | Amount | |
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. 8. | | | | |
| <i>9</i> . | | | | |
| 10. | | | | |
| 11. | | | | |
| 12. | | | | |
| 13. | | | | |
| 14. | | | | |
| 15. | | | | |
| 16. | | | | |
| 17. | | | | |
| 18. | | | | |

*Unit - list a measurable description of the item (gauge, gm, ml, bag, doz., etc.)

Form distribution: (Use carbon paper)

Original - Medical Supply Coordinator **Copy** - Source of Supply

INCIDENT RE-IMBURSEMENT OF ANY SUPPLIES/EQUIPMENT WILL BE BASED <u>ONLY</u> UPON ORIGINAL FORM LISTINGS.

I-MC-312 (1/8/92)