# SENECA COUNTY E.M.S.
# SUPPLEMENTAL RUN SHEET

**Squad Name** _____ **Date** _____

Location of Call _____ Squad Run No. _____

Patient Name _____ Page _____ of _____ County Run No. _____ COUNTY USE ONLY

**NARRATIVE AND/OR TREATMENT CONTINUED FROM PAGE** _____

MEDICAL REFUSAL FORM - The grave nature of my illness and/or injury have been explained to me and I understand that my refusal of treatment and/or transport is against medical advice and may endanger my life. The undersigned hereby releases this department and Seneca County E.M.S., its officers, agents and employees from any and all claims and damages resulting directly or indirectly in connection with the undersignee's refusal.

Patient Signature _____ Date _____/_____ 20_____

Witness Signature _____ Witness Signature _____

☐ NON-INJURY ACCIDENT: LIST NAMES AND ADDRESSES OF ALL OCCUPANTS. _____

**NARRATIVE:** _____

**CREW MEMBERS AND TRAINING LEVEL**

I EMT - P
II EMT - I
III EMT - B
IV Other (Specify)

1. _____ Driver Signature
2. _____ Signature
3. _____ Signature
4. _____ Signature