# Fauquier County Volunteer Fire and Rescue Association EMS Committee

### Quality Assurance Form A

Year: 2018Jan-MarApril-June _X_Jul-SepOct-Dec				
Department Name: _				
Total calls for this pe	eriod: Total calls reviewed for this period:			
Are there any calls th	ne provider or agency would like the committee to review?			
If yes, please l	ist date/report # and briefly describe the reason for review:			
If yes, please l	ist date/report # below:			
Totals:				
ALS	Other (Canceled, no treatment required, etc.)			
BLS	Refusals			
Date submitted:	Submitted by:			
Contact email: Contact phone:				

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### Quality Assurance Form B

Year: 2018Jan-MarApril-June _X_Jul-SepOct-Dec				
Department Name:				
Indicator #1: Protocol training				
How many providers were trained with the roll out?				
ALS				
BLS				
Indicator #2: Stroke calls				
How many calls were run with stroke as a chief complaint:				
Of those, how many were:				
Γransported to FQ ER: Transferred to Aircare:				
Refusals:				

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### Quality Assurance Form B

Indicator #3: BLS drug box	usage	
How many calls involved usi	ng the BLS drug box:	
Please indicate the following	:	
Report #	Call Type	Medication used
Date submitted:	_ Submitted by: _	
Contact email:	Contact number:	
Unless otherwise specified,	it is not necessary to subn	nit copies of any reports that

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meet the indicators outlined on Form B.