Office of EMS and Trauma System
Fax: (702) 383-1240

Exemplary Performance Recognition Form

Name of Provider_____

Provider's Agency_____

This form is a tool for the communication of exemplary performance by a prehospital provider. Please use the space below to describe how the provider exceeded expectations without giving any identifying patient data. Fax the form to the Health District and we will forward it to the appropriate agency.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Individual completing form:_____
Hospital:_____
Date:_____