

## County of Santa Clara Emergency Medical Services System

Form # 903 System Performance Variance Report

REPORTING PARTY		
Name: Title/P	osition: Agency	<u>.                                    </u>
Date and Time of Incident:	Date and Time of Rep	ort:
County Event Number: Agency Event Number:		r:
Phone #:	E-Mail:	Other:
Reported to:	Title/Position:	Agency:
SELECT LEVEL AND TYPE OF VARIANCE:		
Level A Variance	Level B Variance	Level C Variance
<ul> <li>Threat to Public Safety</li> <li>Negative Patient Outcome due to Medication Error or Policy Violation</li> <li>Public Concern/Media</li> </ul>	<ul> <li>Potential Clinical Care Variance</li> <li>Potential Policy Variance</li> <li>Interagency Coordination</li> <li>General Complaint (Public)</li> <li>Communications System Variance</li> </ul>	<ul> <li>□ Good Patient Outcome</li> <li>□ Outstanding Customer Service</li> <li>□ Provider Agency/Hospital</li> <li>□ Field Provider</li> <li>□ Other: Describe Below</li> </ul>
Immediately notify the EMS Duty Chief via County Communications	□ Other: Describe in part 2 below	
NARRATIVE OF VARIANCE:		
Include specific and detailed information about incident location, times, persons involved, witnesses, actions taken, notifications given, and anything else relevant. Continue on additional pages if needed.		
ATTACHMENTS:		
☐ Patient Care Report ☐ Dispa☐ Incident Report ☐ Witne	atch Records   Recordings ess List   Other	□ Photos
Submit this form and all attachments to your EMS Program Manager and the Santa Clara County EMS Agency		
E-mail: reports@ems.sccgov.org Fax: (408).885.3538		