MEDICAL SUPPLY
RECEIPT AND INVENTORY FORM

INCIDENT NAME:_____ **INCIDENT #:**_____

A. Supplies/Equipment received **from**:_____DATE:___/___/____

Agency:_____ Unit ID#:_____ Name:_____
(Whenever possible, use masking tape and markers to identify all equipment)

B. Supplies/Equipment Received **by:**

NAME:_____ **INCIDENT POSITION:**_____

No.	Item Description ***(Print All Entries)***	Unit*	Amount
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
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 ONLY UPON ORIGINAL FORM LISTINGS.

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