F I R E D E P A R T M E N T
9 METROTECH CENTER BROOKLYN N. Y. 11201-3857

Ambulance Call Report (ACR) UNIT
BUREAU OF SUPPORT SERVICES Room 1S-8

NAME AND MAILING ADDRESS

_____

_____

_____

ZIP

TODAY'S DATE: _____

PATIENT'S NAME: _____

AMBULANCE CALL REPORT REQUEST

Please provide us with the notarized signed authorization of the patient or patient's family, along with the information requested below. Please include a check or money order for 75¢, for ambulance calls before 6/10/98, and $1.50 for ambulance call on or after 6/10/98, payable to the NYC Fire Department, along with a self-addressed, stamped envelope.

You may be able to obtain the requested information also by contacting the medical records section of the receiving hospital.

Patient's Date Of Birth: _____ **Patient's SS#** _____ _____ _____

Patient's Home Tel.: _____ **Patient's Age** _____

Patient's Address: _____

(CROSS STREET AND/OR BUILDING ADDRESS)

Date of incident: _____ **Time of incident:** _____

Location of incident: _____

The Hospital patient was taken to: _____

Is a copy of the ambulance bill attached? Yes ☐ No ☐

Ambulance bill account number: (This is the ACR number) _____

4 digit FDNY/EMS Job Number from 911 print-out: _____

Ambulance unit identification or 4 digit badge number: _____

Subpoena Docket No.: _____

PLEASE NOTE: A SIGNED NOTARIZED AUTHORIZATION FROM THE PATIENT OR PATIENT'S FAMILY OR APPROPRIATE GOVERNMENT AGENCY IS REQUIRED. INCOMPLETE FORMS WILL BE RETURNED.PLEASE MAKE SURE ALL THE INFORMATION REQUESTED IS SUPPLIED.

DO NOT WRITE BELOW THIS LINE

- ❑ **Enclosed find photocopy of A.C.R.**
- ❑ **No ambulances were called to this location.**
- ❑ **Patient was transported by a private ambulance.**
- ❑ **No Ambulance Call Report on file for this patient.**

Date: _____ **Searched by:** _____