



East Central Illinois EMS

Agency: _____ Unit: _____

Month: _____ Year: _____

Controlled Substance Daily Security Log

Date <i>(MM/DD/YY)</i>	Time	Bag # <i>(If Applicable)</i>	Drug Box/Bag Tag #	Signature # 1 & Badge # <i>(Off-Going Advanced Provider)</i>	Signature # 2 & Badge # <i>(On-Coming Advanced Provider)</i>

* New forms should be started on the 1st of every month. Return the completed form to the East Central EMS office
**If there is a discrepancy, a supervisor should be notified immediately and Risk Screen filled out



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