East Central Illinois EMS

Agency: _____ Unit: _____

Month: _____ Year: _____

Controlled Substance Daily Security Log

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

* 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

Mar 2019

East Central Illinois EMS

Date *(MM/DD/YY)*	**Time**	**Bag #** *(If Applicable)*	**Drug Box/Bag Tag #**	**Signature # 1 & Badge #** *(Advanced Provider)*	**Signature # 2 & Badge #** *(Advanced Provider)*

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