Note: This is a fill and print form

BRITISH COLUMBIA | Ministry of Health

INTRAVENOUS EXPERIENCE LOG

ATTENDANT: _____ License # _____ EMPLOYEE # _____

REPORTING PERIOD From: _____ To: _____ OPERATOR # _____

DATE	PATIENT'S NAME	FIELD STARTS			IN HOSPITAL STARTS			
		Response Number	Number of Attempts	Cath. Size	Hospital Dept.	Number of Attempts	Cath. Size	Nurse's Signature

NOTE: Reporting period is 12 months, commencing January 1st.

ORIGINAL: Mail or Fax to: EMA LICENSING BRANCH
Ministry of Health Planning
PO Box 9625 Stn Prov Govt
Victoria BC V8W 9P1
Facsimile: (250) 952-1222

COPY: STATION RECORDS

HLTH 2573 REV. 2005/07/19

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